Application for a §1915 (c) HCBS Waiver

Submitted by:

New York State Department of Health

Submission Date:	December 12, 2005

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Abstract:

This is a request for a new waiver. The intent of the waiver is to provide an alternative to nursing home placement for individuals with disabilities who are at least eighteen (18) years of age.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to waiver participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including waiver participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, waiver participant-centered desired outcomes for the delivery of waiver services, including assuring waiver participant health and welfare. It also stresses the importance of respecting the preferences and autonomy of waiver participants. The Framework identifies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy that promotes the achievement of the desired outcomes expressed in the Quality Framework.

HCBS Quality Framework

Focus	Desired Outcome
Waiver participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Waiver participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each waiver participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve waiver participants.*
Waiver participant Safeguards	*Waiver participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Waiver participant Rights and Responsibilities	*Waiver participants receive support to exercise their rights and in accepting personal responsibilities.*
Waiver participant Outcomes and Satisfaction	*Waiver participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports waiver participants efficiently and effectively and constantly strives to improve quality.*

State:	New York State
Effective Date	December 9, 2005
Revision Date	June 9, 2006

1. Request Information

A. The **State** of **New York** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional*): Nursing Home Transition and Diversion Medicaid Waiver

C. Type of Request *(select only one)*:

X	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #**		
	CMS-Assigned Waiver Number (*CMS Use*):		
	Attachment #1 contains the transition plan to the new waiver.		
O	**Renewal (5 Years) of Waiver #**		

D. Type of Waiver *(select only one)*:

O	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver,** as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: April 1, 2006

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	O	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	O	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	O	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the program*:			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program*:			
X	Not applicable			

2. Brief Program Description

Brief Program Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Nursing Home Transition and Diversion (NHTD) Medicaid Waiver will provide community-based alternatives to individuals with disabilities, who are at least eighteen (18) years old, and eligible for nursing facility placement. The NHTD will allow waiver participants to avoid or transition from unwanted nursing home placement.

Designed to promote waiver participant choice, NHTD waiver participants will choose:

(1) to receive NHTD services instead of nursing home services;
(2) to receive NHTD services instead of other Home and Community Based Services (HCBS) Medicaid Waiver services for which they may be eligible;
(3) their service providers; and
(4) what services to receive.

The NHTD structure is modeled after New York's successful 1915(c) Traumatic Brain Injury Medicaid Waiver. Within the first three years, this application is requesting to serve at least five thousand (5000) individuals, who are eligible for nursing home care, to remain in or return to the community. Such individuals will be eligible to receive a variety of comprehensive community-based services and supports.

The New York State Department of Health (DOH), Office of Medicaid Management (OMM), Division of Consumer and Local District Relations (DCLDR), Bureau of Long Term Care (BLTC) is responsible for the operation and oversight of the NHTD. In order to promote efficiency and allow for regional flexibility, DOH will contract with not-for-profit agencies in nine (9) regions across the state with demonstrated experience providing community-based services to individuals with disabilities and seniors. These agencies will serve as Regional Resource Development Centers (RRDCs) and employ Regional Resource Development Specialists (RRDSs). The RRDCs will be responsible for determining waiver participant eligibility, reviewing Service Plans, meeting regional aggregate budgeting targets, organizing local outreach efforts, developing regional resources, making recommendations to DOH about enrolling waiver services providers, and training service providers. In order to further assure the health and welfare of waiver participants, each RRDC will employ a Nurse Evaluator (NE) who will evaluate, as necessary, new waiver participants and waiver participants returning to the community for the potential need for medically related waiver services.

In order to assure implementation of its Quality Management Program, DOH will contract with Quality Management Specialists (QMSs). These Quality Management Specialists will work closely with DOH to implement a quality management program, liaise between DOH, RRDCs and service providers, review Service Plans that have a budget over an amount to be determined by DOH and provide technical assistance to the RRDSs.

An essential component to the implementation of the NHTD is the waiver participant's right to choose a service provider, especially his/her Service Coordinator. At the regional level, RRDSs will be responsible for providing unbiased and comprehensive information to enable potential waiver participants to make informed decisions about whom to choose as a Service Coordinator. The Service Coordinator is crucial to the waiver participants' success in the community, as they work with the waiver participant in the development, implementation, and evaluation of the Service Plan. The Service Coordinator is responsible for assuring the waiver participant's choice of other providers. The NHTD will be provided via the

provider managed method.

The NHTD is one of the initial steps toward the restructuring of New York State's long-term care system.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Waiver participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of waiver participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Waiver participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Waiver participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the waiver participant-centered service plan (of care).

E. Waiver participant-Direction of Services. When the State provides for waiver participant direction of services, **Appendix E** specifies the waiver participant direction opportunities that are offered in the waiver and the supports that are available to waiver participants who direct their services. *(Select one)*:

O	The waiver provides for waiver participant direction of services. *Appendix E is required.*
X	Not applicable. The waiver does not provide for waiver participant direction of services. *Appendix E is not included.*

F. Waiver participant Rights. **Appendix F** specifies how the State informs waiver participants of their Medicaid Fair Hearing rights and other procedures to address waiver participant grievances and complaints.

G. Waiver participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in item I.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

X	Yes
O	No
O	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
X	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies*:
☐	**Limited Implementation of Waiver participant-Direction**. A waiver of statewideness is requested in order to make waiver participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Waiver participants who reside in these areas may elect to direct their services as provided by the State or receive the same services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation are specified in **Appendix B**.

D. Choice of Alternatives: When an individual is determined to be likely to require the level of care specified for this waiver and is in the target group(s) specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: Absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a waiver participant-centered service plan (of care) is developed for each waiver participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the waiver participant, their projected amount, frequency and duration and the type of provider who furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the waiver participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is

not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the waiver participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict waiver participant access to specific waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a waiver participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b)(4) or another section of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431, Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of waiver participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications (d); waiver participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The development of the NHTD was authorized by legislation directing DOH to apply for a Nursing Facility Transition and Diversion Medicaid Waiver. This legislation was supported by advocates for seniors and individuals with disabilities.

In addition, public input was obtained through meetings held with various provider associations and Independent Living Centers, a series of presentations, and a Request for Information (RFI). The RFI was issued on May 6, 2005 and over eighty (80) responses were received from the following stakeholders: Independent Living Centers/Advocates (14 responses); Providers (20 responses); Professional Associations (8 responses); Local Government (32 responses); and State Government (3 responses).

In addition to the RFI and meetings, an Advisory Group was also convened to provide input on various issues as they relate to the development of the NHTD. This Advisory Group was formed in June 2005 and is comprised of representatives from various entities that include, but are not limited to, advocates, community based service providers, NYS Public Welfare Association and state and local governments from across New York State. The Advisory Group continues to meet and to discuss the development and implementation of the NHTD.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments maintaining a primary office and/or majority population within the State of the

State's intent to submit a Medicaid waiver request or renewal request to CMS to at least 60 days before the anticipated submission date per Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficiency Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficiency persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficiency persons.

7. Contact Person(s)

A. The State Medicaid Agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Bruce
Last Name	Rosen
Title:	Director, Nursing Home Transition and Diversion Medicaid Waiver
Agency:	New York State Department of Health
Address 1:	99 Washington Avenue
Address 2:	Room 826
City	Albany
State	New York
Zip Code	12260
Telephone:	518-486-3154
E-mail	BHR01@health.state.ny.us
Fax Number	518-474-7067

B. If applicable, the State Operating Agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J and any attachments, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form when requested by CMS through the Medicaid Agency or, if applicable, from the waiver operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted in writing by the State Medicaid Agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the waiver and will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Kathryn
Last Name	Kuhmerker
Title:	Director, Office of Medicaid Management
Agency:	New York State Department of Health
Address 1:	Corning Tower, Empire State Plaza
Address 2:	
City	Albany
State	New York
Zip Code	12237
Telephone:	518-474-3018
E-mail	KLK03@health.state.ny.us
Fax Number	518-486-6852

Attachment #1: Transition Plan to New Waiver

Note: Attachment #1 is completed only when a state proposes a new waiver to replace an existing waiver program.

Specify the transition plan from the current waiver to the new replacement waiver:

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

X	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):		
	X	Office of Medicaid Management	, the Medical Assistance Unit.
	○		, another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. *Do not complete item A-2.*
○	The waiver is operated by		a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency. *Complete item A-2.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses and the frequency of their use to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements:

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency or the waiver operating agency (if different than the Medicaid agency) (s*elect one)*:

X	Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or waiver operating agency.
○	Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency.

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and specify the type of entity *(check each that applies)*:

X	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	The Local Department of Social Services (LDSS) will assist with the dissemination of information on the NHTD waiver and make referrals as appropriate.
X	**Local/regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
	DOH, BLTC will contract with not-for-profit entities in nine (9) regions across the state with demonstrated experience in conducting waiver operational functions and activities.
☐	**Not applicable** – All waiver operational and administrative functions are performed by a state agency. *Do not complete items A-5 and A-6.*

5. Responsibility for Assessment of Performance of Local/Regional Non-State Entities. Specify the State agency that is responsible for assessing the performance of non-state entities that conduct waiver operational and administrative functions:

The State Agency responsible for assessing the performance of non-state entities that conduct waiver operational and administrative functions is the DOH, Office of Medicaid Management (OMM), Division of Consumer and Local District Relations (DCLDR), Bureau of Long Term Care (BLTC).

6. Assessment Methods. Describe the methods that the State uses and the frequency of their use to assess the performance of non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements:

DOH, BLTC will contract with not-for-profit entities in nine (9) regions across the state with demonstrated experience in conducting waiver operational functions and activities. These agencies will serve as RRDCs. The State will assess these RRDCs for their performance of waiver functions which they are responsible for, in an ongoing regular basis, using divergent methods. These methods and frequency of their use is specified below.

In addition, DOH, BLTC will contract with Quality Management Specialists (QMS) to conduct oversight and quality assurance activities. The QMS assists the RRDSs with review of the Incident Reporting Forms especially when there is an allegation of abuse, neglect or when a waiver participant dies.

DOH will require quarterly reports from the RRDCs and the QMS, and maintain a database to evaluate trends. QMS will participate with DOH on an expected to be established Quality Advisory Board. DOH and the QMS will conduct retrospective annual reviews of a random sample of Service Plans

along with targeted reviews. This will include a statistically significant sample (10% year one, 5% year two and 2% year three) of approved Service Plans from across the nine regions that may be selected based on geography, population density, age, gender, ethnicity, transition and diversion from a nursing home placement. DOH will meet with the RRDS and the QMS on a quarterly basis. There will be annual on-site visits, for review of operational and administrative performance, along with retrospective reviews of a random sample of Service Plans to assure quality performance of these entities. Annual Regional Forums will be established. This will provide an opportunity for DOH to meet with waiver participants, families, advocates and providers to gather information regarding how the waiver is functioning in each region. This meeting will provide DOH information about how the RRDS and the QMS have been performing. In addition, DOH will have regular telephone calls with the RRDS, which will provide DOH with information regarding the RRDS' functioning. It is expected that DOH will also receive calls from the waiver participant, family members, advocates, waiver service providers, Local Departments of Social Services and QMS, which will also contribute to DOH's assessment of the RRDS.

The State expects to establish a toll-free hotline specific to the NHTD waiver participants, their families and advocates for registering complaints and concerns**.** This will include a regular reporting and tracking process to describe types of calls received, the providers and the regions involved. A waiver participant survey process will also be implemented as another means to track and assess the RRDS's and QMS's performance of waiver functions and activities.

DOH is committed to ongoing technical assessment and assistance with these contracted agencies on a regular basis.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect conducting the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☒	☐	☒	☒
Assist individuals in waiver enrollment	☐	☐	☒	☐
Manage waiver enrollment against approved limits	☒	☐	☒	☐
Monitor waiver expenditures against approved levels	☒	☐	☒	☐
Conduct level of care evaluation activities	☐	☐	☒	☐
Review waiver participant service plans to ensure that waiver requirements are met	☒	☐	☒	☐
Perform prior authorization of waiver services	☐	☐	☒	☐
Conduct utilization management functions	☒	☐	☒	☐
Provider recruitment	☐	☐	☒	☐
Execute the Medicaid provider agreement	☒	☐	☐	☐
Determine waiver payment amounts or rates	☒	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	☒	☐	☒	☐

Appendix B: Waiver participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup.*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
X	**Aged or Disabled, or Both**			
X	Aged (age 65 and older)			X
X	Disabled (Physical) (under age 65)	18		
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limitation on individuals who may be served in the waiver, describe the transition planning procedures for waiver participants affected by the age limit *(select one)*:

X	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for waiver participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

X	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete item B-2-b or item B-2-c.*
O	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver by an amount specified by the State. *Complete items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
	O ____ %, a level higher than 100% of the institutional average
	O Other *(specify)*:
O	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the 100% of the cost of the level of care specified for the waiver. *Complete items B-2-b and B-2-c.*
O	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that limit is sufficient to assure the health and welfare. Of waiver participants. Complete items B-2-b and B-2-c. :*
	The cost limit specified by the State is *(select one)*:
	O The following dollar amount: $ ____
	The dollar amount *(select one)*:
	O Is adjusted each year that the waiver is in effect by applying the following formula:
	O May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	O The following percentage that is less than 100% of the institutional average: ____ %
	O Other – *Specify:*

b. Method of Implementation of Cost Limit. When an individual cost limit is specified in item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Waiver participant Safeguards. When the State specifies an individual cost limit in item B-2-a and there is a change in the waiver participant's condition or circumstances that requires the provision of services that exceed the cost limit in order to assure the waiver participant's health and welfare, the State provides the following safeguards to avoid an adverse impact on the waiver participant (*check each that applies*):

☐	The waiver participant is referred for services in another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Waiver participants. The following table specifies the maximum number of unduplicated waiver participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of waiver participants specified for any year(s), including when a modification is necessary due to legislative appropriation or other reason. The number of unduplicated waiver participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Waiver participants
Year 1	1000
Year 2	2500
Year 3	5000
Year 4 (renewal only)	
Year 5 (renewal only)	

b. Limitation on the Number of Waiver participants Served at Any Point in Time. Consistent with the unduplicated number of waiver participants specified in Item B-3-a, the State may limit to a lesser number the number of waiver participants who will be served at any point in time during a waiver year. Select whether the State limits the number of waiver participants in this way: *(select one)*:

X	The State does not limit the number of waiver participants that it serves at any point in time during a waiver year.
○	The State limits the number of waiver participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Waiver participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver participant Capacity. The State may reserve a portion of the waiver participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

X	Does not reserve capacity.
O	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of waiver participants who are served subject to a phase-in or phase-out schedule *(select one):*

X	The waiver is not subject to a phase-in or a phase-out schedule.
O	The waiver is subject to a phase-in or phase-out schedule that is included in Appendix J. This schedule constitutes an ***intra-year*** limitation on the number of waiver participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

O	Waiver capacity is allocated on a statewide basis.
X	Waiver capacity is allocated to local non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is employed to allocate capacity; and, (c) policies for the reallocation of unused capacity among local non-state entities:

For purposes of this waiver, New York State is divided into nine regions, with estimated capacity being allocated by the State to the contracted RRDC located in each region. DOH will allocate the estimated opportunities to the RRDCs based on population and expected numbers of providers in each region, historical to participation in other waivers. The NHTD allows for "portability", where waiver participants, who maintain eligibility, are free to move from one geographic region to another within the state while maintaining waiver services.

Flexibility of opportunities will exist, so that the DOH will have the ability and responsibility to move unused opportunities from one region to another region which has otherwise fully utilized its allocated opportunities. This method of allocation and reallocation as needed has worked effectively in the ten year operation of the TBI waiver. No waiver applicant has ever been denied admission to that waiver because of lack of opportunities in one region while other regions had unused opportunities.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The individual must choose to participate in the waiver program, and there must be available resources. After all eligibility criteria has been met, the applicant is selected for entrance to the waiver based on the date of approval of their application, which includes the Initial Service Plan and proof of Medicaid eligibility, active Medicaid status and disability. Consideration will be given for applicants with imminent need for waiver services.

Although the State establishes regional aggregate budget targets, as explained in Appendix B-3.e, the State allows for fluidity between the regions. For example, if a potential waiver participant's Service Plan causes a region to exceed its aggregate budget target, the State may allow that region to enroll that individual in the NHTD. This decision is contingent upon another region in the state having room in their budget cap. This region must have a similar number of waiver participants, and under by the equivalent amount that the original region would be over its budget target.

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

X	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
X	Low income families with children as provided in §1931 of the Act			
X	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
X	Optional State supplement recipients			
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	○	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
X	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
X	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 group as provided in §1902(e)(3) of the Act)			
X	Medically needy (42 CFR §435.320, §435.322, §435.324 and §435.330)			
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
☐	All individuals in the special home and community-based waiver group under 42 CFR 435.217			
X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
	☐	A special income level equal to (select one):		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)
		○	$	which is lower than 300%

	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
	☐	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
	☐	Aged and disabled individuals who have income at: *(select one)*		
		○	100% of FPL	
		○	%	of FPL, which is lower than 100%
	X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
		42 CFR 435.217, Disabled individuals who are at least eighteen years old.		

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a waiver participant with a community spouse.

a. Applicability *(select one)***:**

X	**Yes**. As provided in Appendix B-4, the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Complete item B-5-b and other related items.
O	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Do not complete the remainder of this Appendix.

b. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a waiver participant with a community spouse, the State elects to (*select one*):	
	O	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-c-2 (SSI State) or B-5-d-2 (209b State) and Item B-5-e.*
	X	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-c-1*) or under §435.735 (209b State) (*Complete Item B-5-d-1*)
O	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State).*	

[Items B-5-c-1 and B-5-d-1 are for use by states that do not use spousal eligibility rules or use special post eligibility rules but elect to use regular post-eligibility rules].

c-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
X	The following standard included under the State plan *(select one)*			
	O	SSI standard		
	O	Optional State supplement standard		
	X	Medically needy income standard		
	O	The special income level for institutionalized persons *(select one):*		
		O	300% of the SSI Federal Benefit Rate (FBR)	
		O	%	of the FBR, which is less than 300%
		O	$	which is less than 300%.
	O	%		of the Federal poverty level
	O	Other (specify):		

■			
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. <u>Allowance for the spouse only</u> (*select one*): The rest of this section is per the NYS Plan.

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*: The rest of this section is per the NYS Plan.

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

iv. The State also will deduct medical and remedial care expenses specified in 42 CFR §435.726.

d-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
    - [ ]
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ [ ] % of the FBR, which is less than 300%
    - ○ $ [ ] which is less than 300% of the FBR
  - ○ [ ] % of the Federal poverty level
  - ○ Other (specify):
    - [ ]
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:
  - [ ]

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
  - [ ]
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
  - [ ]
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard

○	Medically needy income standard
○	The following dollar amount: $ _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. The State also will deduct medical and remedial care expenses specified in 42 CFR §435.735.

[NOTE: (not part of application) Items B-5-c-2 and B-5-d-2 are for use by states that use spousal eligibility rules and elect to apply the special post eligibility rules.

c-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable Per CMS Region II the state is using rules indicated in State Plan.

iii. Allowance for the family *(select one)*:

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions) Per Region II, the state is using rules indicated in the State Plan.
iv. The State also will deduct medical and remedial care expenses specified in 42 CFR §435.726.	

d-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
ii. <u>Allowance for the spouse only</u> (*select one*):				

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable		

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. The State also will deduct medical and remedial care expenses specified in 42 CFR §435.735.

e. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a waiver participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the waiver participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State plan.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
X	The following dollar amount:	$ **	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		
	**The personal needs allowance (PNA) is equal to the difference between the amounts of the Medical Assistance eligibility standard for one person and two person household.		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

The PNA will be used for "institutionalized" spouses who reside with their spouses in the community by virtue of the receipt of home and community-based services. The PNA represents the additional amount of income which is exempted from medically needy persons under New York State's Medicaid statute when a household of one becomes a household of two.

Appendix B-6: Evaluation/Reevaluation of Level of Care

a. Evaluation of Level of Care. As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

b. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services: (a) the individual must require the provision of at least [1] (*insert number*) service(s) offered under the waiver; and, (b) the individual must require the provision of waiver services at least monthly or, if less frequently, require regular monthly monitoring as documented in the service plan.

c. Fair Hearing. As specified in Appendix F, the State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals who are determined not to meet the level of care requirements for this waiver.

d. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
X	Other (*specify*):
	By professionals trained and certified by New York State for completion of Patient Review Instrument (PRI) and SCREEN.

e. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The PRI and SCREEN are the tools used for initial evaluation. The PRI must be completed by a certified NYS Registered Nurse, following completion of an appropriate PRI Training Program. The SCREEN must be completed by a professional who has completed an appropriate SCREEN Training Program.

f. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria are available through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

To participate in this waiver program, the nursing facility level of care is necessary. Level of care is determined through completion of the PRI and SCREEN.

The purpose of the PRI instrument is to identify medical events including medical conditions and treatments; capabilities of the individual to perform Activities of Daily Living (ADLs); behavioral difficulties; and specialized services which will result in the potential waiver participant's level of care.

The SCREEN serves two purposes. The first purpose is to determine the individual's potential to be cared for in a non-nursing home setting based on the availability of appropriate community-based living arrangements, informal supports, the need for restorative services, and the ability to reside in the community without undue risk to self or others, and whether there is a need for nursing home level of care.

The second purpose is to assess an individual for potential mental illness, mental retardation or developmental disabilities and the need for specialized services.

g. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
O	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

h. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

DOH will employ use of a PRI and SCREEN to determine a potential waiver participant's initial level of care. The documents will be completed only by individuals trained and certified in the use of the PRI and SCREEN.
The completion of this documentation may occur in three instances:

1. For individuals living in the community, the community based certified Evaluator will complete the PRI and SCREEN.
2. For individuals in hospitals and nursing homes, the PRI and SCREEN completed by the institution's trained and certified assessors will be used. These assessment tools must have been completed within 90 days of the initial referral to the waiver.
3. DOH reserves the right to have the RRDC Nurse Evaluator complete another PRI and SCREEN whenever there is concern about the accuracy of the PRI and SCREEN completed by another certified individual.

Reevaluation of a waiver participant's level of care will occur on an annual basis or when a waiver participant has experienced significant changes in physical, cognitive or behavioral status. The PRI and SCREEN will be used in the reevaluation process, completed by NYS certified assessors.

i. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a waiver participant are conducted no less frequently than annually according to the following schedule

(select one):

O	Every three months
O	Every six months
X	Every twelve months
O	Other schedule (*specify*):

j. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
O	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

k. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The Service Coordinator is responsible for developing and maintaining a database to track dates when reevaluation of level of care is due. This is needed to ensure the waiver participant's eligibility to continue on the waiver program. A component of Service Coordination is to have the reevaluations submitted into the Regional Resource Development Specialist (RRDS) 4-6 weeks prior to the due date to ensure no interruption of service. The RRDS will also have a database to ensure this process is managed and that service plans are received prior to the due date. Databases designed to track the timely submission of service plans and level of care determinations are currently in use in another waiver program (TBI waiver). The State will evaluate the existing databases to determine which is the most comparable to what is needed for this waiver. Any modifications that are needed will be completed prior to the enrollment of participants and will be used throughout the state**.** If the RRDS does not receive the PRI and SCREEN in a timely manner, s/he will notify the Service Coordinator.

l. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Service Coordinator and the RRDS are both responsible for the safe retention of all records for at least three (3) years. The records will be maintained in their agency ensuring that they will be readily retrievable if requested by CMS or the DOH.

Appendix B-7: Freedom of Choice

a. Freedom of Choice. When an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

b. Fair Hearing. As specified in Appendix F, the State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, subpart E, to individuals who are not informed of any feasible alternatives under the waiver or given the choice of home or community-based waiver services.

c. Procedures. Per 42 CFR §441.303(d), specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services.

DOH recognizes its responsibility to inform potential waiver participants of their right to Freedom of Choice. The RRDS, in the initial meeting with the potential waiver participant, informs him/her that they have a choice between living in a nursing home or living in the community supported by available services and supports, including services available through this waiver. Each potential waiver participant will sign a Freedom of Choice form, signifying his/her preference.

d. Freedom of Choice Documentation. Attachment #1 to Appendix B-7 contains a copy of the form used to document freedom of choice.

e. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

For all waiver participants who have chosen waiver services and have been approved to participate in the waiver program, copies of the completed Freedom of Choice forms will be maintained for at least three (3) years in the RRDC and in the Service Coordinator's office.

Appendix B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficiency Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficiency persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Potential and active waiver participants with limited fluency in English must have access to services without undue hardship. RRDCs must have arrangements to provide interpretation or translation services for potential and active waiver participants who need them. This is accomplished through a variety of means including; employing bi-lingual staff, resources from the community (e.g. local colleges) and if necessary contracting with interpreters. Those who are non-English speaking may bring a translator of their choice with them to meetings with waiver providers and/or the RRDS. However, they may not be required to bring their own translator, and no person can be denied access on the basis of a RRDCs inability to provide adequate translations.

Attachment #1 to Appendix B-7

Include the form used to document Freedom of Choice

Attachment #1 to Appendix B-7

HOME AND COMMUNITY BASED SERVICES
NURSING HOME TRANSITION AND DIVERSION MEDICAID WAIVER

FREEDOM OF CHOICE

I, _____ have been informed that I am eligible for care provided through either a Skilled Nursing Facility or the Home and Community Based Services Nursing Home Transition and Diversion (NHTD) Medicaid Waiver Program and I have

_____ chosen

_____ not chosen

to receive services through the NHTD Program.

_____	_____
Applicant Name	Legal Guardian Name
_____	_____
Applicant Signature	Legal Guardian Signature
_____	_____
Date	Date

_____
RRDS Name

_____
RRDS Signature

_____
Date

Appendix C: Waiver participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under this waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	X	Service Coordination
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	X	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Independent Living Skills Training Services
b.	Structured Day Program Services
c.	Positive Behavioral Interventions and Supports Services

d.	Community Integration Counseling Services
e.	Home and Community Support Services
f.	Community Transitional Services
g.	Environmental Modifications Services
h.	Assistive Technology Services
i.	Congregate and Home Delivered Meals Services
j.	Respiratory Therapy Services
k.	Moving Assistance Services
l.	Nutritional Counseling/Educational Services
m.	Home Visits by Medical Personnel
n.	Wellness Counseling Service
o.	Peer Mentoring

Extended State Plan Services *(select one)*

X	Not applicable
	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Waiver participant Direction *(select one)*

○	The waiver provides for waiver participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for waiver participant direction.
X	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Waiver participant Direction	☐	
Financial Management Services	☐	

Other Supports for Waiver participant Direction *(list each support by service title)*:

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver participants. When case management is not a waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☐	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management on behalf of waiver participants:

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning conducting criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available through the Medicaid or the operating agency (if applicable):
	Operators of residential health care facilities, licensed home care agencies, certified home health agencies, personal care services agencies are mandated to use criminal history record checks. 10 NYCRR through Sections 400.23, 763.13, 766.11 and 18 NYCRR 505.14 have been amended to require operators to obtain a criminal history record report from the United States Attorney General (Attorney General) for all prospective employees prior to employment. An employee is defined as any person employed by the facility or program providing direct care or supervision to patients (waiver participants), other than those persons licensed under Title 8 of the Education Law or Article 28-D of the Public Health Law. Verification of compliance with the criminal history record check regulations are included in DOH's surveillance process. At the time of surveillance, DOH surveyors utilize a standardized tool to evaluate compliance with the criminal history background checks regulations. If a provider is found to not be in compliance with the regulations, a statement of deficiency(ies) is issued for which the provider has to provide a plan of correction. Licensed Home Care Agencies and Certified Home Health Agencies are surveyed, at a minimum, one time every three (3) years.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available through the Medicaid agency or the operating agency (if applicable):
X	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete items c.i – c.ii.*
X	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available through the Medicaid agency or the operating agency (if applicable). *Complete items c.i –c.ii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Adult Care Facility (Adult Home)	Service Coordination, Assistive Technology, Community Integration Counseling, Community Transitional Services, Home and Community Support Services, Independent Living Skills Training, Moving Assistance, Nursing Assessment, Positive Behavioral Interventions and Supports, Respiratory Therapy, Home Visits by Medical Personnel, Peer Mentoring	200 beds
Enriched Housing	Service Coordination, Assistive Technology, Community Integration Counseling, Community Transitional Services, Home and Community Support Services, Independent Living Skills Training, Moving Assistance, Nursing Assessment, Positive Behavioral Interventions and Supports, Respiratory Therapy, Home Visits by Medical Personnel, Peer Mentoring	N/A
Residential Programs for Adults	Service Coordination, Assistive Technology, Community Integration Counseling, Community Transitional Services, Home and Community Support Services, Independent Living Skills Training, Moving Assistance, Nursing Assessment, Positive Behavioral Interventions and Supports, Respiratory Therapy, Home Visits by Medical Personnel, Peer Mentoring	48 beds

ii. Larger Facilities: In the case of residential facilities that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

DOH, through its survey process evaluates the home and community character of Adult Care Facilities, enriched housing programs and residences for adults.

Adult Care Facilities (Adult Homes) are established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator. Adult Care Facilities (Adult Homes) are congregate facilities where residents can choose their room based on availability. Adult Care Facilities (Adult Homes) provide for a minimum of three congregate meals in communal dining areas and an evening snack. Residents are also permitted to keep food in their room if desired. Residents are encouraged to participate in facility and community activities. In addition, each Adult Care Facility (Adult Home) has a diversified program of individual and group activities that provides for activities within the facility and arranges for resident participation in community-based and community-sponsored activities. Each resident has the opportunity to have private communications. Each facility must provide, without charge, space for residents to meet in privacy with service providers. Adult Care Facility (Adult Home) residents are permitted to leave and return to the facility at reasonable hours. Residents may also choose their own community-based health care

providers, have their own motor vehicles and furnish/decorate and maintain their rooms.

Enriched Housing Programs are adult-care facilities established and operated for the purpose of providing long-term residential care to five or more adults, primarily persons 65 years of age or older, in community-integrated settings resembling independent housing units. Such programs provide or arrange the provision of room, and provide board, housekeeping, personal care and supervision. Enriched Housing Programs must serve at a minimum, one hot midday or evening meal per day seven days a week in a congregate setting. In addition, residents have free access to kitchen facilities for the purpose of preparing their own noncongregate meals and snacks and may keep food in their housing unit as desired. Enriched Housing staff assists residents, to the extent necessary, with shopping, preparation and clean-up of noncongregate meals. Residents are encouraged to maintain family and community ties and to develop new ones, as well as participate in community activities. Each resident has the opportunity to have private communications. Enriched Housing Programs provide, free of charge, space for residents to meet in privacy with service providers. Residents are able to leave and return to the facility as desired. In addition, residents may choose their own community-based health care providers, have their own motor vehicles and furnish/decorate and maintain their own housing unit.

The purpose of Residential Programs for Adults is to provide residential services which support and assist individuals diagnosed with a severe and persistent mental illness with their goal of integration into the community. Services provided in such programs focus upon intensive, goal-oriented intervention, within a structured program setting, to address issues identified by and specific to resident's needs regarding community integration or goal oriented interventions which focus on improving or maintaining resident skills that enable a resident to remain living in community housing. Types of residential programs include apartment and congregate living. No more than two persons can share a bedroom and each resident must have at least 75 square feet of living space if sharing a bedroom. Residents may furnish/decorate and maintain their rooms. The program provides room and board within stable housing with on-site services which is supported by transportation activities and other services within the community.

iii. Scope of State Facility Standards. By type of facility listed in item C-2-c-I, specify whether the State's standards address the following topics *(check each that applies)*:

Standard	Facility Type Adult Home	Facility Type Residence for Adults	Facility Type Enriched Housing	Facility Type Residential Programs for Adults
Admission policies	X	X	X	X
Physical environment	X	X	X	X
Sanitation	X	X	X	X
Safety	X	X	X	X
Staff : resident ratios	X	X	X	X
Staff training and qualifications	X	X	X	X
Staff supervision	X	X	X	X
Resident rights	X	X	X	X

Medication administration	X	X	X	X
Use of restrictive interventions	X	X	X	X
Incident reporting	X	X	X	X
Provision of or arrangement for necessary health services	X	X	X	X

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of waiver participants is assured in the standard area:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services. Specify in Appendix C-3 the personal care or similar services for which such payment may be made to legally responsible individuals, the legally responsible individuals who may furnish such services, State policies that specify the extraordinary circumstances when such payments may be authorized, and the controls that are employed to ensure that payments are made only for services rendered:

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

X	The State does not make payment to relatives/legal guardians for furnishing waiver services.
	The State makes payment to relatives/legal guardians under exceptional circumstances. Specify the exceptional circumstances under which payment is made and the types of relatives/legal guardians to whom payment may be made. Specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians. Specify the controls that are employed to ensure that payments are made only for services rendered:
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide service. Specify the controls that are employed to ensure that payments are made only for services rendered.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers:

DOH and/or its contractor will pursue an aggressive outreach and publicity program to result in the opportunity for any and all providers who are willing and qualified to enroll as a waiver service Medicaid provider.

DOH and/or its contractor will conduct statewide regional meetings and open forums along with information sessions in order to educate the community at large about the NHTD waiver. The RRDS will be directed by DOH to facilitate meetings with potential providers to inform them of the opportunities to provide waiver services.

Outreach and publicity materials will be published to provide necessary information on the NHTD waiver. Public outreach will continue with the utilization of press releases, articles and other media as approved by DOH, to ensure equity of opportunity.

The recently submitted NHTD waiver application is on the DOH website, as will be the final application approved by CMS and the program manual, providing ready access, to the necessary information for all potential providers. Providers may seek to enroll at anytime during the course of the waiver.

The process is as follows:

1) An entity informs DOH or RRDC of its interest in becoming a provider.
2) The potential provider is then directed to the DOH website, which explains the process for becoming a provider and furnishes the necessary forms: the Provider Agreement and the Medicaid Enrollment forms.
3) The potential provider is then interviewed by the RRDS, using a standard interview form. The RRDS reviews the Policy and Procedures developed by the potential provider.
4) The RRDS reviews the interview form, and then makes a recommendation to DOH.
5) DOH reviews the recommendations of the RRDS and if it concurs, the provider is approved for participation.
6) Information is then sent to eMedNY, which enters the provider in the system. The provider receives official notification of approval, and a Billing Manual.

Any willing and qualified provider may, at any time, seek approval for adding services. If a provider seeks to be approved for additional services, the RRDS will once again interview the provider as mentioned above.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Service Coordination
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Service Coordination is an individually designed intervention which provides primary assistance to the waiver participant in gaining access to needed waiver and Medicaid State Plan services, as well as other local, state and federally funded educational, vocational, social, medical, and any other services. These interventions are expected to result in assuring the waiver participant's health and welfare and increasing independence, integration and productivity. In addition, for potential waiver participants desiring to transition from unwanted nursing home placement, the Service Coordinator will assist them in obtaining and coordinating the services that are necessary to return to the community.

The Service Coordinator will assist the waiver participant in the development of the individualized Service Plan, and will include those individuals chosen by the waiver participant to also participate in the process. Following the approval of the Service Plan, the Service Coordinator will assist the waiver participant in implementing the plan, as well as reviewing its effectiveness. Throughout his/her involvement with the waiver participant, the Service Coordinator will support and encourage the waiver participant to increase his/her ability to problem-solve, be in control of life situations, and be independent. The Service Coordinator will also assist the waiver participant to complete the Plan of Protective Oversight, see Appendix D.

The Service Coordinator is responsible for the timely submission of subsequent Service Plans and for ongoing monitoring of the provision of all services included in Service Plans.

The Service Coordinator is responsible for assuring that all waiver providers and others, as appropriate, have a copy of the Initial Service Plan and is provided with the most recently approved Service Plan.

The Service Coordinator will initiate and oversee the process of assessment and reassessment of the waiver participant's level of care (i.e. need for nursing home level of care) and review of Service Plans at such intervals as specified in Appendix D of this request.

The Service Coordinator is also responsible for assuring that Team Meetings are scheduled and held as designated in the Service Plan, as well as for providing all waiver providers and other waiver participants in the Team Meetings with written summaries of the meetings.

All Service Coordination must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. Qualifications of the providers are found below. The provision of Service Coordination under this waiver is cost effective and necessary to avoid institutionalization. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or for profit health and human service agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	Persons employed as Service Coordinators must be a: (A) Master of Social Work, Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group (A) shall have, at a minimum, one (1) year of experience providing Service Coordination and information, linkages and referral regarding community based services for individuals with disabilities and/or seniors; OR (B) Be an individual with a Bachelor's degree and two (2) years experience providing Service Coordination to

			individuals with disabilities and/or seniors and knowledge about community resources; (C) Be an individual with a High School Diploma with three (3) years experience providing Service Coordination for individuals with disabilities and/or seniors and knowledge about community resources; OR (D) Be an individual who has successfully served as a Regional Resource Development Specialist for one (1) year. Individuals with the educational experience listed in Group (A) but who do not meet the experience qualification; individuals with a Bachelor's degree in health or human services with one (1) year of experience providing Service Coordination for individuals with disabilities and/or seniors and knowledge about community resources; and individuals with a High School Diploma and two (2) years of experience providing Service Coordination to individuals with disabilities and/or seniors with knowledge about community resources must be supervised by individuals identified in Group (A). For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Initial Service Plan developed by a Service Coordinator under their supervision; have supervisory meetings with staff on at least a bi-weekly basis; and review and sign-off on all Service Plans.
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of	Other standards are the same as above.

		Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.	

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or for profit health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually

			thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Respite Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Respite Services is an individually designed service intended to provide relief to natural, non-paid supports who provide primary care and support to a waiver participant. The primary location for the provision of this service is in the waiver participant's home. Respite Services are provided in a 24 hour block of time.

Respite Services may be provided in the waiver participant's home or in another dwelling. Services may be provided in another dwelling in the community if this is acceptable to the waiver participant and the people living in the other dwelling. If a waiver participant is interested in seeking a brief respite in a nursing home, this can be accomplished through a Scheduled Short Term Admission, and is not considered a Waiver Service.

Providers of the Respite Services must meet the same standards and qualifications as the direct care providers of Home and Community Support Services (HCSS). If the services needed by the waiver participant exceed the type of care and support provided by the Home and Community Support Services, then other appropriate providers must be included in the plan for Respite Services and will be reimbursed separately from Respite Services.

Respite Services must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Agencies approved to provide Home and Community Support Services (HCSS)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Agencies approved to provide HCSS.			Staff providing Respite must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service. In addition, staff providing Respite must have a certificate to indicate that they have successfully completed a training program for Personal Care Aides that is approved by DOH.

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	**Agencies approved to provide HCSS.**	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Independent Living Skills Training Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Independent Living Skills Training Services (ILST) are individually designed to improve or maintain the ability of the waiver participant to live as independently as possible in the community. ILST will primarily be targeted to those individuals with progressive illnesses to maintain essential skills. ILST may be provided in the waiver participant's residence and in the community. This service will be primarily provided on an individual basis; only in the unique situation, where the waiver participant will receive greater benefit from other than a 1:1 situation, will a group method of providing service be approved.

ILST must be provided in the situation which will result in the greatest positive outcome for the waiver participant. It is expected that this service will be provided in the waiver participant's environment; for example, in the waiver participant's kitchen as opposed to a provider's kitchen. This expectation is based on the difficulty that many waiver participants experience with transferring or generalizing knowledge and skills from one situation to another. It is recognized that there is a need for some practice of skills before using them in the environment.

Services may include assessment, training, and supervision of an individual with self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving, money management, pre-vocational skills and ability to maintain a household.

This service may also be used to assist a waiver participant in returning to, or expanding the waiver participant's involvement in meaningful activities, such as volunteering or paid employment. The use of this service for these purposes must occur only after it is clear that the waiver participant is not eligible for these services through either the Vocational and Educational Services for Individuals with Disabilities (VESID) or the Commission for the Blind and Visually Handicapped (CBVH); that VESID and CBVH services have been exhausted; or the activity is not covered by VESID or CBVH services.

It is expected that ILST providers will train natural supports, paid staff and waiver providers to provide the type and level of supports that allows the waiver participant to act and become as independent as possible in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This service may continue only when the waiver participant has reasonable goals. It is used for training purposes and not ongoing long term care supports. Reasons to provide or continue this service must be clearly stated in the Service Plan.

Independent Living Skills Training and Development under this waiver is cost-effective and necessary to avoid institutionalization.

All ILST must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Provider Specifications				
Provider Category(s) *(check one or both)***:**		Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or for profit health and human service agency.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-Profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	Persons employed as ILST staff must be a: (A) Master of Social Work, Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group A must have, at a minimum one (1) year of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent; OR

			(B) An individual with a Bachelor's degree and two (2) years of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent; OR (C) An individual with a High School Diploma and three (3) years of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent. Individuals with the educational experience listed in Group (A), but who do not meet the experience qualifications; individuals with a Bachelor's degree and less than one (1) year experience; individuals with a High School Diploma and less than two (2) years experience; and individuals who have successfully completed two (2) years of providing Home and Community Support Services or Residential Habilitation under the New York State Office of Mental Retardation and Developmental Disabilities HCBS Waiver must be supervised by an individual identified in Group (A) For purposes of supervision, the supervisor is expected to meet any potential waiver participants prior to the completion of the Detailed Plan developed by the ILST under their supervision; work with the ILST on completing the functional assessment of the participant; work with the ILST to re-evaluate the participant as needed, but not less than at the completion of the Revised Service Plans and whenever Addenda to the Service Plan are written; have supervisory meetings with staff on at least a bi-weekly basis; provide ongoing supervision and training to staff; and review and sign-off on all Detailed

			Plans.
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.	Other standards are the same as above.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or for profit health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any

			subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Structured Day Program Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Structured Day Program Services are individually designed services provided in an outpatient congregate setting or in the community, to improve or maintain the waiver participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision to an individual with self-care, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills and ability to maintain a household.

This service may augment some aspects of this waiver, other services, as well as Medicaid State Plan services when reinforcement of skills is necessary. This is due to the difficulty that many individuals have with transferring or generalizing skills learned in one setting to other settings, and the need for consistent reinforcement of skills. The Service Plan should address how the services are complimentary and not duplicative. This service is intended to provide an opportunity for the waiver participant to continue to strengthen skills that are necessary for greater independence, improved productivity and/or increased community inclusion.

The Structured Day Program may be provided within a variety of settings and with very different goals. Waiver participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other waiver participants, for whom employment is not an immediate or long-term goal, may focus on socialization skills.

The Structured Day Program is responsible for providing appropriate and adequate space to meet the functional needs of the waiver participants served. The program must provide adequate protection for the program waiver participants' safety and fire safety, including periodic fire drills, and must be located in a building that meets all provisions of the NYS Uniform Fire Prevention and Building Codes. In addition, access to the program must meet and adhere to requirements of the Americans with Disabilities Act. The RRDS or DOH may determine the appropriateness of the physical space for the NHTD waiver participants.

The provision of Structured Day Programs under this waiver is cost-effective and necessary to avoid institutionalization.

The Structured Day Program must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or for profit health and human service agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-Profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	The provider types at the left must have a Structured Day Program Director who is a: (A) Master of Social Work, Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Individuals in Group (A) must have, at a minimum, one (1) year of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors: OR

			(B) be an individual with a Bachelor's degree and two (2) years of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors. In addition to a required Program Director, a Structured Day Program may employ program staff. Program staff must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service.
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for	Other standards are the same as above.

		the purpose of providing health and/or human services related activities.	

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or for profit health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Positive Behavioral Interventions and Supports
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Positive Behavioral Interventions and Support (PBIS) services are individually designed and are provided to waiver participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment.

These services include but are not limited to: a comprehensive assessment of the individual's behavior in the context of their medical diagnosis, disease progression, skills and abilities, existing and potential natural and paid supports and the environment; the development and implementation of a holistic structured behavioral treatment plan (Detailed Plan) including specific realistic goals which can also be utilized by other providers and natural supports; the training of family, natural supports and other providers so that they can also effectively use the basic principles of the behavioral plan; and regular reassessment of the effectiveness of the behavioral treatment plan, making adjustments to the plan as needed.

The primary focus of the Detailed Plan for this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors.

The Detailed Plan must include a clear description of successive levels of intervention, starting with the simplest and least intrusive level. All plans must be written in a manner so that all natural and paid supports will be able to follow the plan. An emergency intervention plan is warranted when there is the possibility of the waiver participant becoming a threat to him or herself or others.

The two key positions in PBIS are the Program Director and the Behavioral Specialist. The Program Director is responsible for assessing the waiver participant and developing the PBIS plan for each waiver participant. The Director may work as a Behavioral Specialist, or may provide ongoing supervision to a Behavioral Specialist who will implement the plan. If a provider has more than one individual who meets the qualifications for the Program Director, all qualified individuals may develop individual PBIS plans. The Behavioral Specialist is responsible for implementation of the Detailed Plan under the direction of the Program Director.

The PBIS should be provided in the situation where the significant maladaptive behavior occurs. The provision of PBIS must be documented in the Service Plan and be provided by agencies approved as a provider of this waiver service by DOH.

The provision of PBIS under this waiver is cost effective and necessary to avoid institutionalization. The cost effectiveness of this services is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or for profit health and human service agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	The providers listed at the left must employ a Program Director who is a: (A) Licensed psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law) with one year experience providing behavioral services; (B) Licensed psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law) with one year experience in providing behavioral services; (C) Master of Social Work, Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Language Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered

			Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services; (D) An individual who has been a Behavioral Specialist for two (2) years and has successfully completed a apprenticeship program offered by the Statewide Neurobehavioral Resource Project. A Behavioral Specialist must be a: (A) Person with a Bachelor's degree; (B) Licensed Practical Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law); (C) Certified Occupational Therapy Assistant (certified by the NYS Education Department pursuant to Article 156 of the NYS Education Law); or (D) Physical Therapy Assistant (certified by the NYS Education Department pursuant to Article 136 of the NYS Education Law). Behavioral Specialists must have at least one year of experience working with individuals and/or seniors with disabilities or behavioral difficulties. The Behavioral Specialist must successfully complete training in behavioral analysis and crisis intervention techniques which is provided by the Positive Behavioral Interventions and Supports program. The Behavioral Specialist must be supervised by the Program Director. Supervision must occur no less than biweekly to review the caseload and must be more frequent when there is a new waiver participant, new provider or when significant behavioral issues arise.
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation	Other standards are the same as above.

		Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.	

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or for profit health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon

			hire and annually thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Community Integration Counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Community Integration Counseling is an individually designed service intended to assist waiver participants who are experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability and living in the community. It is a counseling service provided to the waiver participant who is coping with altered abilities and skills, a revision of long term expectations or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the waiver participant's home. It is available to waiver participants and/or anyone involved in an ongoing significant relationship with the waiver participant when the issue to be discussed relates directly to the waiver participant.

This service differs from Medicaid State Plan services in that only those professionals listed who meet specific experiential standards will be eligible for reimbursement for this service.

While Community Integration Counseling Services are primarily provided in a one-to-one counseling sessions, there are times when it is appropriate to provide this service to the waiver participant in a family counseling or group counseling setting.

The provision of Community Integration Counseling under this waiver is cost-effective and necessary to avoid institutionalization. All Community Integration Counseling must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**		Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or for profit health and human service agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	Staff of providers at the left must be a: (A) Licensed Psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law); Licensed Psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law); Master of Social Work; Master of Psychology; Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification); or Certified Special Education Teacher (Certified by the NYS Education Department). Each of these individuals must have, at a minimum, two (2) years of experience providing adjustment related counseling to individuals and/or seniors with physical and/or cognitive disabilities and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with disabilities and/or seniors and their families in order to be considered qualifying experience. Individuals listed in Group (A) may supervise the following individuals to perform Community Integration Counseling services: (B) Licensed Psychiatrist (licensed by the NYS Education Department pursuant to Article 131 of the NYS Education Law); Licensed Psychologist (licensed by the NYS Education Department pursuant to Article 153 of the NYS Education Law); Master of Social Work; Master of Psychology; Certified Rehabilitation Counselor (Certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification). Individuals in Section (B) may have less than two (2) years experience providing adjustment related counseling to individuals and/or seniors with physical,

			cognitive, developmental or psychiatric disabilities
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.	Other standards are the same as above.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or for profit health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its

			contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Home and Community Support Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Home and Community Support Services (HCSS) are the combination of personal care services (ADLs) and (IADLs) with oversight/supervision services or oversight/supervision as a discrete service. HCSS is provided to a waiver participant who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight/supervision of the participant is required when no personal care task is being performed. Services will be complimentary but not duplicative of other services.

HCSS services are provided under the direction and supervision of a Registered Professional Nurse. The Registered Professional Nurse supervising the HCSS staff is responsible for developing a plan and for orienting the HCSS staff.

HCSS differ from the personal care services provided under the Medicaid State Plan in that oversight/supervision is not a discrete task for which personal care services are authorized.

The provision of HCSS under this waiver is cost-effective and necessary to avoid institutionalization.

All HCSS must be documented in the Service Plan and provided by agencies approved as a provider of waiver services by DOH. The cost effectiveness of this service is found in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**		Individual. List types:	X	Agency. List the types of agencies:
				Licensed Home Care Services Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person		Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Home Care Services Agency	Licensed under Article 36 of the NYS Public Health Law or exempt from licensure pursuant to 10 NYCRR 765-2.1c		Staff must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service. In addition, staff providing HCSS must have a certificate to indicate that they have successfully completed a training program for Personal Care Aides that is approved by DOH, as well as any additional training as determined by DOH. The HCSS aides must also be in good physical health; that includes documentation of a yearly physical exam, immunizations, a yearly Mantoux skin test and a declaration that one is free from health impairments which pose potential risks to waiver participants or personnel; HCSS aides must be supervised by a Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of NYS Education Law). Nursing supervision must be provided by a registered professional nurse who: (a) is licensed and currently certified to practice as a registered professional nurse in New York State; (b) be in good physical health that the Department of Health requires for employees of certified home health agencies that includes documentation of a yearly physical exam, immunizations, a yearly Mantoux skin test and a declaration that one is free from health impairments which pose potential risks to patients or personnel; and (c) meets either of the following qualifications: (1) has at least two years satisfactory recent home health care experience; or (2) has a combination of education and experience equivalent to the requirement described in (1) of this section, with at least one year of home health care experience; or

			acts under the direction of a registered professional nurse who meets the qualifications listed in (a) and (b) of this section and either of the qualifications listed in (1) or (2) of this section.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Licensed Home Care Services Agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:		Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Community Transitional Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Community Transitional Services (CTS) are defined as individually designed services intended to assist a waiver participant to transition from a nursing home to living in the community. CTS is a one time service per waiver enrollment. If the waiver participant has been discontinued from the program and now is a resident of a nursing home, they can access this service again, if needed. This service is only provided when transitioning from a nursing home. These funds are not available to move from the participant's home in the community to another location in the community. The funding limits for this service are separate and apart from the limits applied to Moving Assistance, and the two services will not be used at the same time in any approved Service Plan.

This service includes: the cost of moving furniture and other belongings, security deposits, including broker's fees required to obtain a lease on an apartment or home; purchasing essential furnishings; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or one time cleaning prior to occupancy.

The service will not be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems.

The provision of CTS under this waiver is cost-effective and necessary to avoid institutionalization.

All CTS must be documented in the Service Plan. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maximum up to $5000 per waiver enrollment.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or proprietary health and human service agency that provides Service Coordination**.** This does not have to be the same agency as the agency providing Service Coordination to the waiver participant.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	For the provider types listed at the left, persons employed as Service Coordinators and provide CTS must be a: (A) Master of Social Work, Master of Psychology, Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Certified Special Education Teacher (certified as a Special Education Teacher by the NYS Education Department), Certified Rehabilitation Counselor (certified as a Certified Rehabilitation Counselor (CRC) by the Commission on Rehabilitation Counselor Certification), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers in Group (A) shall have, at a minimum, one (1) year of experience providing Service Coordination and information, linkages and referral regarding community based services for individuals with disabilities and/or seniors; OR (B) Be an individual with a Bachelor's degree and two (2) years experience providing Service Coordination to individuals with disabilities and/or seniors and knowledge about community resources; (C) Be an individual with a High School Diploma with three (3) years experience

			providing Service Coordination for individuals with disabilities and/or seniors and knowledge about community resources; OR (D) Be an individual who has successfully served as a Regional Resource Development Specialist for one (1) year. Individuals with the experience listed in Group (A) but who do not meet the experience qualification; individuals with a Bachelor's degree in health or human services with one (1) year of experience providing Service Coordination for individuals with disabilities and/or seniors and knowledge about community resources; and individuals with a High School Diploma and two (2) years of experience providing Service Coordination to individuals with disabilities and/or seniors and knowledge about community resources must be supervised by individuals identified in Group (A).
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section	Other standards are the same as above.

		121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.	

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or proprietary health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer must verify license or certification upon hire and annually thereafter. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Environmental Modifications Services (E-mods)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Environmental Modifications (E-mods) are internal and external physical adaptations to the home, which are necessary to assure the health, welfare and safety of the waiver participant. These modifications enable the waiver participant to function with greater independence and prevent institutionalization. E-mods may include: the installation of ramps and grab bars; widening of doorways; modifications of bathroom facilities; installation of specialized electrical or plumbing systems to accommodate necessary medical equipment; or any other modification necessary to assure the waiver participant's health, welfare or safety.

E-mods do not include improvements to the home (e.g. carpeting, roof repair, central air conditioning), which are not medically needed or do not promote the waiver participant's independence in the home or community.

An E-mod may alter the basic configuration of the waiver participant's home if this alternation is necessary to successfully complete the modification.

Modifications must be provided where the waiver participant lives. If a waiver participant is moving to a new location which requires modifications, the modifications may be completed prior to the waiver participant's move. Also, if an eligible individual is residing in an institution at the time of application, the modifications may be completed no more than 30 days prior to the waiver participant moving into the modified residence. All modifications must meet State and local building codes.

Modifications may also be made to a vehicle if it is the primary means of transportation for the waiver participant. This vehicle may be owned by the waiver participant; a family member who has consistent and on-going contact with the waiver participant; or a non-relative who provides primary, long term support to the waiver participant. These modifications will be approved when the vehicle is used to improve the waiver participant's independence and inclusion in the community.

All E-mods must be documented in the Service Plan and provided by agencies approved by DOH. The cost-effectiveness of this service in demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limit of up to $15,000 per twelve month period. A contract for Environmental Modifications in the amount of $15,000 or more must be approved by DOH.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Any not-for-profit or proprietary health and human service agency may provide

		Environmental Modifications or may subcontract with a qualified person or entity to provide Environmental Modifications. Agencies approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD) may be approved by DOH to provide this service for the NHTD waiver.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	The E-mod provider must ensure that individuals working on the E-mods are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements. Providers must adhere to safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes.
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS	Other standards are the same as above.

		Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.	

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Any not-for-profit or proprietary health and human service agency may provide Environmental Modifications or may subcontract with a qualified person or entity to provide Environmental Modifications. Agencies approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD) may be approved by DOH to provide this service for the NHTD waiver.	DOH and/or its contractors for provider type. For Employer-Employee or subcontractors, the employer/contractor is responsible for verifying that the individual(s) have the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:	Assistive Technology			
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:				
○	Service is included in current waiver. There is no change in service specifications.			
○	Service is included in current waiver. The service specifications have been modified.			
○	Service is not included in the current waiver.			
Service Definition (Scope)**:**				
The purpose of this service is to supplement the Medicaid State Plan Service for durable medical equipment and supplies, which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other sources must be explored and utilized before considering Assistive Technology. An Assistive Technological device may include an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve functional capabilities of waiver participants. Assistive Technology service is a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. This service will only be approved when the requested equipment and supplies improve or maintain the waiver participant's level of independence, ability to access needed supports and services in the community or the waiver participant's safety. Documentation must describe how the waiver participant's expected use, purpose and intended place of use have been matched to features of the products requested in order to achieve the desired outcome in an efficient and cost effective manner. The provider of this service is responsible for training the waiver participant, natural supports and paid staff who will be assisting the waiver participant in using the equipment or supplies. Assistive Technology must be documented in the Service Plan and provided by agencies approved by DOH. The cost effectiveness of this service is demonstrated in Appendix J.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Limit of up to $15,000 per twelve month period. A contract for Assistive Technology in the amount of $15,000 or more must be approved by DOH.				
Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Providers of Assistive Technology must be approved by DOH under Section 504 of Title 18 NYCRR; approved to provide Assistive Technology by OMRDD; a licensed pharmacy; or for Personal Emergency Response Systems (PERS), an approved provider of Personal Emergency Response

		Systems (PERS) which have existing contracts with Local Department of Social Services (LDSS).

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Pharmacy			An establishment registered as a pharmacy by the State Board of Pharmacy pursuant to Article 137 of the NYS Education Law
Approved providers of PERS			Provider of PERS contracted with the LDSS
Providers approved by DOH			Approved under Section 504 of Title 18 NYCRR
Providers approved by OMRDD			Approved to provide Assistive Technology by the NYS Office of Mental Retardation and Developmental Disabilities

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Providers of Assistive Technology must be approved by DOH under Section 504 of Title 18 NYCRR; approved to provide Assistive Technology by OMRDD; a licensed pharmacy; or an approved provider of Personal Emergency Response Systems (PERS) which have existing contracts with the LDSS.	DOH and/or its contractors for provider type.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC).

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Congregate and Home Delivered Meals
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Congregate and Home Delivered Meals is an individually designed service which provides meals to waiver participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. These meals will assist the waiver participant to maintain a nutritious diet. These meals do not constitute a full nutritional regimen. It is not to be used to replace the regular form of "board" associated with routine living in an Adult Care Facility. Individuals eligible for non-waiver nutritional services would access those services first.

Congregate and Home Delivered Meals must be documented in the Service Plan and provided by agencies approved by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Entities that contract with Area Agencies on Aging to provide Congregate and/or Home Delivered Meals.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Area Agencies on Aging contracted Congregate and/or Home Delivered Meal providers	Pursuant to NYCRR Title 18 Parts 461		

	and 488; NYCRR Title 10, Part 14		

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Area Agencies on Aging contracted Congregate and/or Home-Delivered Meal providers	DOH and/or its contractors for provider type.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC).

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Respiratory Therapy

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Respiratory Therapy is an individually designed service**,** specifically provided in the home, intended to provide preventative, maintenance, and rehabilitative airway-related techniques and procedures. Respiratory Therapy services include application of medical gases, humidity and aerosols; intermittent positive pressure; continuous artificial ventilation; administration of drugs through inhalation and related airway management; individual care; and instruction administered to the waiver participant and natural supports.

Respiratory Therapy services must be documented in the Service Plan and provided by agencies approved by DOH. The cost effectiveness of this service is demonstrated in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**		Individual. List types:	X	Agency. List the types of agencies:
				Certified Home Health Agencies, Hospitals, Nursing Facilities, providers of Respiratory Therapy and Equipment

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Hospital	Licensed under Article 28 of the New York State (NYS) Public Health Law		Staff providing Respiratory Therapy must be licensed and currently registered as a Respiratory Therapist pursuant to Article 164 of the NYS Education Law.
Nursing Facility	Licensed under Article 28 of the NYS Public		Staff providing Respiratory Therapy must be licensed and currently registered as a Respiratory Therapist pursuant to

	Health Law		Article 164 of the NYS Education Law.
Certified Home Health Agency	Licensed under Article 36 of the NYS Public Health Law		Staff providing Respiratory Therapy must be licensed and currently registered as a Respiratory Therapist pursuant to Article 164 of the NYS Education Law.
Providers of Respiratory Therapy and Equipment			Staff providing Respiratory Therapy must be licensed and currently registered as a Respiratory Therapist pursuant to Article 164 of the NYS Education Law.

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Certified Home Health Agencies, Hospitals, Nursing Facilities, providers of Respiratory Therapy and Equipment	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification					
Service Title:	Moving Assistance				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
○	Service is included in current waiver. There is no change in service specifications.				
○	Service is included in current waiver. The service specifications have been modified.				
○	Service is not included in the current waiver.				
Service Definition (Scope)**:**					
Moving Assistance Services are individually designed services intended to transport a waiver participant's possessions and furnishings when the waiver participant must be moved from an inadequate or unsafe housing situation to a viable environment which more adequately meets the waiver participant's health and welfare needs and alleviates the risk of unwanted nursing home placement. Moving Assistance may also be utilized when the waiver participant is moving to a location where more natural supports will be available, and thus allows the waiver participant to remain in the community in a supportive environment. Moving Assistance is only available to waiver participants who reside in the community. It differs from Community Transitional Services (CTS) as CTS is only available to waiver participants who are transitioning from a nursing home. The funding limits for this service are separate and apart from the limits applied to CTS, and the two services will not be used at the same time in any approved Service Plan. Moving Assistance must be documented in the Service Plan and provided by agencies approved by DOH. The cost effectiveness of this service is documented in Appendix J.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
$5,000 per twelve month period. DOH may increase this amount to $10,000 per twelve month period.					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Approved Service Coordination provider will subcontract with a licensed moving company

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Approved Service Coordination provider			Must meet qualifications of an approved Service Coordination provider as defined above.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Approved Service Coordination provider	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Peer Mentoring

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Peer Mentoring is an individually designed service intended to improve the waiver participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This will be accomplished through education, teaching, instruction, information sharing, and self-advocacy training.

This service is based on the belief that often people with disabilities who are struggling to regain a self satisfying life may best benefit from relating to another person with a disability who has been successful in this effort. At the same time, there exist attitudinal and physical barriers placed in the way of individuals with disabilities who are seeking their rightful place in the society. A Peer Mentor is able to examine these barriers and assist the waiver participant to overcome them. This service is not intended to meet the waiver participant's needs for a mental health professional's services, which may be necessary due either to a condition which existed prior to the onset of the disabilities or which may have occurred following the onset of the disability. The provider of this service will develop an ongoing relationship with a local provider of mental health services for mutual training, and when appropriate, referral by one entity to the other to assure that waiver participants receive the most appropriate services.

A waiver participant may receive this service as well as professionally provided mental health services as long as the need for both is clearly explained in the Service Plan. This service is provided on and individual basis and specific goals must be established for the individual(s) receiving this service. Peer Mentoring will primarily be available to waiver participants who have recently transitioned into the community from a nursing home or as needed during times of crisis.

Peer mentoring must be documented in the Service Plan. The cost effectiveness of this service is documented in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or for profit health and human service agency

Specify whether the service may be provided by *(check each that*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

applies):			
Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law for the purposes of providing health and/or human services related activities	Persons providing Peer Mentoring must have a significant physical or cognitive disability, successfully demonstrated the ability to maintain a productive life in the community and have at least one (1) year of paid or unpaid experience providing peer mentoring. Individuals employed as Peer Mentors must satisfactorily complete a training approved by DOH which will delineate the roles and responsibilities of the Peer Mentor in relation to other waiver and non waiver services.
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health	Other standards are the same as above.

		and/or human services related activities.	
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or for profit health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying qualifications of employees.	Upon signed provider agreement. The waiver service provider must report any change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer is responsible for verifying qualifications of employees. DOH verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Home Visits by Medical Personnel
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Home Visits by Medical Personnel are individually designed services to provide diagnosis, treatment and wellness monitoring in order to preserve the waiver participant's functional capacity to remain in their own home. Wellness monitoring is critical to the overall health of waiver participants. Wellness monitoring includes disease prevention, the provision of health education and the identification of modifiable health risks. Through increased awareness and education, waiver participants are more apt to make healthy lifestyle choices which will decrease the likelihood of unnecessary institutionalization. The frequency of wellness monitoring will be contingent on the waiver participant's needs.

Home Visits by Medical Personnel will decrease the likelihood of exacerbations of chronic medical conditions and unnecessary and costly emergency room visits, hospitalizations and nursing facility placement. In addition to assessing the waiver participant, this service will also include the evaluation of the home environment from a medical perspective and the waiver participant's natural supports' ability to maintain and/or assume the role of caregiver. The provider's assessment of the natural supports/ caregivers will not be one in which a physical exam is performed; instead the assessment will focus on the natural supports'/caregivers' relationship to the waiver participant in terms of the physical, social and emotional assistance that is currently provided or may be provided in the future. Based on the outcome of this assessment, the provider of this service can make referrals for or request that the Service Coordinator make referrals for additional assistance as appropriate, thus promoting the ability of the waiver participant to remain at home. The provision of this service allows the waiver participant to remain in the least restrictive setting. This service will enhance the quality of medical care and the quality of life of the waiver participant.

Home Visits by Medical Personnel differs from what is offered under the State Plan as this waiver service is used for wellness monitoring, the assessment of the natural supports'/caregivers' ability to provide assistance to the waiver participant, and/or the evaluation of the waiver participant's home environment from a medical perspective.

This service is especially beneficial for those waiver participants who have significant difficulty traveling or are unable to travel for needed medical care provided by a physician, physician's assistant or nurse practitioner because of: (1) severe pain; (2) severe mobility impairments; (3) terminal illness; (4) when travel is contraindicated due to the person's chronic condition; (5) when medical providers at a physician's office and/or transportation providers refuse to provide services due to an individual's disruptive behavior; (6) the home visit is cost-effective or (7) where transportation to medical appointments is limited due to geographical considerations.

The Medical Personnel will perform a comprehensive assessment of the physical, psycho-social,

environmental and economic factors in the waiver participant's own environment that could affect the waiver participant's health and welfare and the ability to remain in the community. This comprehensive assessment and medical follow-up in the waiver participant's home will improve the waiver participant's functioning. As a result of this improved functioning, and by having the Medical Personnel complete a comprehensive assessment in the waiver participant's home, the Medical Personnel is more apt to detect conditions in the home environment that negatively affect the waiver participant's health and welfare and respond accordingly. This preventive activity will decrease the likelihood of accidents in the home, lower the waiver participant's and caregiver's stress level, increase the quality of medical care provided to the waiver participant and increase the efficiency of medication management which will promote the waiver participant's ability to remain at home.

As part of the home visit, the medical personnel will evaluate safety issues and other conditions in the home from a medical perspective. Medical Personnel will conduct a basic assessment of the home environment in relation to the waiver participant's health and welfare. Any concerns about the home environment that may affect the waiver participant's health and welfare will be shared with the Service Coordinator and other relevant members of the team.

The Medical Personnel are an integral part of the waiver participant's service provider team. It is the responsibility of the Medical Personnel to inform the Service Coordinator of any recommendations for services that will meet the waiver participant's medical needs and other significant findings. The Service Coordinator will utilize this information in revising the waiver participant's Service Plan.

Home Visits by Medical Personnel must be provided by entities approved by DOH and documented in the Service Plan. The cost effectiveness of this service is documented in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Physician in private practice or a corporation licensed pursuant to Public Health Law Article 28

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physician in private practice or a corporation licensed pursuant to Public Health Law Article 28		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-for-Profit Corporation Law	Persons providing Home Visits by Medical Personnel shall be a Physician (licensed pursuant to Article 131 of the NYS Medicine Education Law); or a Nurse Practitioner (licensed pursuant to Title 8 Article 139 NYS Education Law) or a Physician's Assistant (licensed pursuant to Article 131b of the NYS

			Medicine Education Law).
		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act	Other standards are the same as above.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Physician in private practice or a corporation licensed pursuant to Public Health Law Article 28	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer is

			responsible for verifying that the individual(s) maintain the needed license or certification. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Nutritional Counseling/Educational Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Nutritional Counseling/Educational Services is an individually designed service which provides an assessment of the waiver participant's nutritional needs and food patterns, and the planning for the provision of food and drink appropriate for the waiver participant's conditions, or the provision of nutrition education, and counseling to meet normal and therapeutic needs. In addition, these services may include assessment of nutritional status and food preferences; planning for the provision of appropriate dietary intake within the waiver participant's home environment and cultural considerations; nutritional education regarding therapeutic diets as part of the development of a nutritional treatment plan; regular evaluation and revision of nutritional plans; and the provision of in-service education to the waiver participant, family, advocates, waiver and non-waiver staff as well as consultation on specific dietary problems of the waiver participants.

Nutritional Counseling/Educational Services must be documented in the Service Plan. The cost effectiveness of this service is documented in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**		Individual. List types:	X	Agency. List the types of agencies:
				A not-for profit or for profit health and human service agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Not-for-profit health and human service agency		Certificate of Incorporation filed with the NYS Department of State pursuant to Section 402 of the NYS Not-	Staff providing Nutritional Counseling/Educational Services must be licensed as a Registered Dietician pursuant to Article 157 of the NYS Education Law or be licensed as a Registered Nutritionist pursuant to

		for-Profit Corporation Law for the purposes of providing health and/or human services related activities	Article 157 of the NYS Education Law.
For profit health and human service agency		Certificate of Incorporation pursuant to Section 402 of the NYS Business Corporation Law; Certificate of Incorporation pursuant to Section 1503 of the NYS Business Corporation Law; Articles of Organization pursuant to Section 203 of the NYS Limited Liability Company Law; Articles of Organization pursuant to Section 1203 of the NYS Limited Liability Law; Certificate of Limited Partnership pursuant to Section 121-201 of the NYS Revised Limited Partnership Act; or Certificate of Registration pursuant to Section 121-1500(a) of the NYS Partnership Act, for the purpose of providing health and/or human services related activities.	Other standards are the same as above.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	A not-for profit or for profit health and human service agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed	Upon signed provider agreement. The waiver service provider must

		license or certification.	report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Wellness Counseling Service

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Wellness Counseling Service is an individually designed service intended to assist the medically stable waiver participant in maintaining optimal health status. It is intended to be available to waiver participants who do not otherwise have access to nursing services. Through Wellness Counseling, a Registered Professional Nurse assists the waiver participant to identify his/her health care needs and provides guidance to the waiver participant to minimize, or in some cases prevent, exacerbations of disease. This service differs from Medicaid State Plan Nursing Service as it provides wellness counseling as a discrete service to medically stable individuals.

Through Wellness Counseling, a Registered Professional Nurse can reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. Additionally, the Registered Professional Nurse will be able to offer support for control of any diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma or high cholesterol.

In addition to these services, the Registered Professional Nurse can assist the waiver participant to identify signs and symptoms that may require intervention so as to prevent further complications from the disease or disorder. If potential complications are identified, the Registered Professional Nurse will counsel the waiver participant about appropriate interventions including the need for immediate medical attention or contact the waiver participant's physician for referral to traditional Medicaid State Plan services. This service will assess the waiver participant's chronic care needs to assure the participant's health status remains stable and at an optimal level to avoid acute episodes and utilize health care resources efficiently and effectively.

Wellness Counseling Service must be documented in the Service Plan and provided by an agency approved by DOH. The cost effectiveness of this service is documented in Appendix J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

It will be limited to no more than twelve visits in a calendar year and will occur on an as needed basis.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Certified Home Health Agency or Licensed Home Care Services Agency

Specify whether the service may be	☐	Legally Responsible Person	☐	Relative/Legal Guardian

provided by *(check each that applies):*				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Home Health Agency	Licensed under Article 36 of the NYS Public Health Law		Staff providing Wellness Counseling Service must be a Registered Professional Nurse pursuant to Article 139 of the NYS Education Law.
Licensed Home Care Services Agency	Licensed under Article 36 of the NYS Public Health Law		Staff providing Wellness Counseling Service must be a Registered Professional Nurse pursuant to Article 139 of the NYS Education Law.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Home Health Agency or Licensed Home Care Services Agency	DOH and/or its contractors for provider type. For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification.	Upon signed provider agreement. The waiver service provider must report any subsequent change in status to DOH and/or its contractors (QMS and/or RRDC). For Employer-Employee, the employer is responsible for verifying that the individual(s) maintain the needed license or certification. DOH will verify employee qualifications and certifications through the DOH surveys and/or audits.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Waiver participant-directed as specified in Appendix E	X	Provider managed

Appendix D: Waiver participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Waiver participant-Centered Service Plan Title:	

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
X	Service Coordinator (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. **Service Plan Development Safeguards.** *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the waiver participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the waiver participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the waiver participant. *Specify*:
	DOH makes every effort to promote the right of waiver participants to choose services and service providers. DOH does allow agencies that provide Service Coordination to provide other waiver services. This is a reflection of the need to accommodate for the state's diversity in culture and language. For example, some waiver providers actually specialize in providing linguistically competent services to waiver participants whose primary language is not English and these waiver providers may offer both Service Coordination and other waiver services. This decision also contributes to assuring that the waiver participants have maximum choice among providers. The following safeguards ensure that the Service Plan development is conducted in the best interests of the waiver participant and assures provider choice: (1) The potential waiver participant first meets with the RRDS to obtain information about the NHTD waiver and information about waiver service

providers. The RRDS explains to the potential waiver participant that he/she has a choice of all waiver service providers and encourages the potential waiver participant to interview Service Coordinators in order to make an informed choice;

(2) The waiver participant must sign a Service Coordinator Selection Form indicating that he/she understands that he/she is entitled to choose a Service Coordinator and approved providers of other waiver services;

(3) The Service Coordinator provides the potential waiver participant with a list of all approved waiver providers;

(4) The waiver participant must sign the list that contains the names of the approved waiver service providers in the region. By signing the list, the waiver participant is affirming that he/she was given a choice of approved waiver providers;

(5) On an annual basis, the waiver participant reviews and signs the Participant Rights Form, which describes the right to choose and change waiver service providers as requested by the waiver participant. The waiver participant maintains a copy of the signed form;

(6) Waiver participant choice is inherent to the Service Plan development process. The Service Coordinator is responsible for providing unbiased and comprehensive information to the waiver participant about available services and service providers.

(7) The waiver participant's signature is required on the Initial Service Plan, the Revised Service Plan and Addendums to the Service Plan. The waiver participant's signature is required in order to indicate that the waiver participant agrees with the information that is included in the Service Plan. This information includes the services requested and the providers of the services;

(8) If the waiver participant does not want to sign the Service Plan, the waiver participant is given the opportunity for Conference with DOH and/or a Fair Hearing;

(9) The waiver participant has the right to change waiver service providers at any time during the period covered by an approved Service Plan. With the assistance of their Service Coordinator, the waiver participant completes a Change of Provider Form, which is then sent to the RRDS. The RRDS sends a Verification of Provider Change Form to the waiver participant, the Service Coordinator and the current and new waiver service providers. If the waiver participant wishes to change Service Coordinators, the waiver participant contacts the RRDS directly. The RRDS will provide information to the waiver participant about providers of Service Coordination and assist the waiver participant with completing the Change of Provider Form;

(10) A toll-free hotline will be established for waiver participants to use if they believe their rights are being violated. All calls to the hotline will be investigated promptly;

(11) All NHTD Waiver service providers will be surveyed at least one time within the first 36 months of the operation of the NHTD Waiver and, at a minimum, every 24-36 months thereafter. Waiver service providers may be surveyed more frequently if DOH identifies concerns about the provider's adherence to waiver requirements. The survey focuses primarily on waiver service provider's compliance with NHTD waiver policies, including the right of a waiver participant to freely choose his/her waiver service provider. If the survey identifies trends that indicate that waiver service providers are not giving a choice, the waiver service provider is subject to remedial action which may include termination of the Provider Agreement with DOH.

(12) QMSs are liaisons between the DOH, RRDCs and waiver service providers. QMSs are responsible for working with DOH to ensure quality management. DOH, through the RRDS, QMS and/or surveyors, will investigate all complaints and implement remedial action as appropriate;

(13) As part of a contact list, the waiver participant is provided with the phone numbers of the RRDS, the QMS and DOH in case any concerns arise;

(14) Waiver participants will be surveyed**,** using a standardized tool to obtain feedback about the services and supports that they receive under the NHTD waiver. This survey will include questions about the waiver participant's satisfaction with the amount of choice and control that they have over their services and over their providers of service;

(15) The RRDS is a separate entity from the provider of service;

(16) The RRDS reviews each Service Plan to assure it is viable and reflects waiver participant choice; and

(17) DOH will retrospectively review at least ten-percent (10%) of Service Plans in Year One, at least five-percent (5%) in Year Two and at least two-percent (2%) in Year Three which will include evaluation of patterns of referrals. This evaluation will be based on the percentage of waiver service dollars that service coordination agencies will be receiving on a statewide and regional basis. If significant patterns of self-interest are discovered, the reasons for this pattern will be explored. This may include a more focused exploration of a larger sample of the provider's billing. Action will be taken as necessary, including training to the service coordination provider on participant rights, interviewing participants, surveys and/or audits and, if needed, termination of the Provider Agreement.

c. Supporting the Waiver participant in Service Plan Development. Specify: (a) the supports and information that are made available to the waiver participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the waiver participant's authority to determine who is included in the process.

The RRDS provides detailed written information to the waiver participant and/or legal guardian regarding the purpose of the NHTD waiver, philosophy of the NHTD waiver, available services, application and Service Plan development process, role of the Service Coordinator and a list of available Service Coordinators. The waiver participant may include any person of his/her choosing to assist in the development of the Service Plan.

d. Service Plan Development Process and Scope. The service plan contains: (a) the waiver services that are furnished to the waiver participant, their projected amount, frequency and duration, and the type of provider who furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the waiver participant. Specify the process that is employed to develop the service plan and the scope of the plan. State laws, regulations, and policies cited that affect the service plan development process are available through the Medicaid agency or other operating agency (if applicable):

The Service Coordinator assists the potential waiver participant with the waiver application process and coordinates and monitors the provision of all services in the Service Plan. He/she will assist the waiver participant in the development of the Individualized Service Plan, and will include those individuals chosen by the waiver participant to also participate in that process. The goal of the Service Plan is to increase the waiver participant's independence, productivity and integration into the community with assurance of the health and welfare of the waiver participant.

Identification of the waiver participant's strengths, abilities, and preferences are the starting point for developing the Service Plan. Each Service Plan will include an assessment of the individual to determine the services needed to prevent institutionalization. The assessment process is completed utilizing a multi-faceted approach which may include self-assessment, speaking with significant others, facilities that the waiver participant has had recent contact and the service providers.

The assessment includes exploring with the waiver participant:

- What are your (the waiver participant's) goals
- What can be done to help the waiver participant fulfill his/her goals
- How can the waiver participant be assisted to become a member of the community
- What can be done to assist the waiver participant to be more independent
- What are the waiver participant's concerns or fears

The Initial Service Plan will include obtaining relevant information which will assist in clarifying the strengths and needs of the potential waiver participant. The planning process for a potential waiver participant who is being deinstitutionalized will include obtaining the final summary of care and the post discharge plan that were prepared by that facility. This will also include speaking with staff involved in a recent discharge from a hospital, affiliation with a home health care agency, a rehabilitation agency or others that are involved with the waiver participant. The Service Coordinator needs to have a full and accurate picture of the potential waiver participant's preferences including such areas as family, marriage, living situation, recreation or leisure time, physical and mental health, spiritual, vocation or job and community service. Please note the assessment will include the following; demographic information, description of the individual in person centered terms, psycho-social history and a needs assessment. The assessment also includes an assessment of risk factors that will be addressed in the Plan for Protective Oversight. This will be discussed in greater detail in D-1 e.

The waiver participant first becomes aware of the available services through the interview process that was conducted by the RRDS at the time of the preliminary screening. The Service Coordinator reviews the services with the waiver participant during the assessment process. The Service Coordinator will present options for meeting the needs and preferences that the waiver participant has deemed to be important. The Service Plan is based primarily on the potential waiver

participant's choice of services and providers, and reflects the potential waiver participant's dignity to risk and right to fail. The potential waiver participant will be afforded the opportunity to have family, friends or advocates participate in the development of the Service Plan. However, the request by a capable potential waiver participant that a representative does not participate in the planning process will be respected unless the representative is a guardian appointed by the court. The development of the Service Plan is not a stagnant process, but one that continues to evolve as the waiver participant requests revisions, experiences significant changes, or as new service options become available. The Service Coordinator is crucial to the waiver participants' success in the community, as they work with the waiver participant in the development, oversee the implementation, monitoring and evaluation of the Service Plan.

The Service Plan that the Service Coordinator and the waiver participant completed will contain the type of waiver services, Medicaid State Plan and/or other services to be furnished, the amount, frequency and duration of each service, and the provider who will furnish each service. This part of the assessment of services will include the waiver service providers who will provide a Detailed Plan to the Service Coordinator. The Service Plan is the essential tool that clearly states responsibility for each of the services and supports that the waiver participant needs based on a comprehensive, person centered assessment. The Service Plan is updated every six months, when there is a significant change in the participant's nee for support and services or his/her life situation, or when requested by a waiver participant. Please refer to D-2-a for additional information on Implementation and Monitoring of the Service Plans**.**

The Service Plan specifies all supports to be provided to the waiver participant, including: informal caregivers (i.e. family, friends, and natural supports); federal and State funded services; Medicaid State Plan services; and waiver services. Waiver services are services that are provided when informal or formal supports are not available to meet the participant's needs. Waiver services may also be accessed when the use of these services maybe more efficient or cost-effective than Medicaid State Plan services.

Further assessments of specific skills are included as a component of the activities associated with waiver services. If the waiver participant's level of skill changes, there will be an appropriate adjustment in the type and amount of the waiver services provided.

The Service Coordinator will assist the waiver participant in obtaining and coordinating the services that are outlined in the Service Plan. The Service Plan must reflect coordination between all providers involved with the waiver participant. It is also necessary to obtain input from the agencies other than waiver service providers that authorize and/or directly provide needed services. Some Medicaid funded services, such as personal care services (known as home attendant services in New York City), require prior authorization from the LDSS.

Every Service Plan and Addendum also includes a signed Plan of Protective Oversight (PPO). The PPO explicitly states the individuals who are responsible for assisting the waiver participant with daily activities/emergencies, medication management, and financial transactions. Fire, safety issues and back-up plans are also included. The PPO is a system in place to reduce risk and address safety issues. The PPO addresses back-up issues for activities which are directly related to health and welfare.

The Service Plan must reflect that the waiver participant was actively involved in the development of the Service Plan. By signing the Service Plan, the waiver participant acknowledges that he/she has contributed to the development of the Service Plan, and agrees with its contents.

e. Risk Assessment and Mitigation. Specify how potential risks to the waiver participant are assessed during the service development process and how strategies to mitigate risk are incorporated into the service plan, subject to waiver participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The NHTD waiver recognizes the waiver participant's right to risk and the dignity to fail, and balances this with the State's responsibilities to assure health and welfare and the waiver participant's right to select their services and providers. It is critical to obtain an accurate picture of what services and supports might be needed to maintain the health and welfare of the waiver participant. Through the development of the Service Plan, which includes the Detailed Plan completed by each service provider, a comprehensive understanding of the waiver participant's level of skills is obtained. This provides the background to understand the areas of activities which may present risks to the waiver participant. The extent of that risk is also evident. Each waiver service provider is responsible for providing feedback to the waiver participant. Every effort is made to assist the waiver participant to understand his/her risks that may be associated with his/her performance of ADLs and IADLs. The waiver participant has the right to accept or reject assistance with or modifications to these activities.

There may come a point when the waiver participant's choices are such that the waiver program becomes concerned that it will not be able to assure the waiver participant's health and welfare. This concern is clearly discussed with the waiver participant. If the waiver participant's health and welfare can be assured, then the waiver participant can remain in the waiver. If this is not possible, then the waiver participant is issued a Notice of Decision, indicating discontinuance from the waiver, with Fair Hearing rights attached.

Every Service Plan and Addendum also includes a signed Plan of Protective Oversight (PPO). The PPO explicitly states the individuals who are responsible for assisting the waiver participant with daily activities, medication management, and financial transactions. Fire, safety issues and back-up plans are also included. The PPO is a system in place to reduce risk and address safety issues. The PPO addresses back-up issues for activities which are directly related to health and welfare. The Service Coordinator is responsible for assuring that the activities outlined in the PPO are carried out and are sufficient.

Participant risk and safety considerations are identified and potential interventions considered that promote independence and safety with informed involvement of the waiver participant.

f. Informed Choice of Providers. Describe how waiver participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The RRDS is responsible for providing the waiver participant with a list of Service Coordinators and encourages them to select one based on an interviewing process.

The Service Coordinator is responsible for ensuring that waiver participants sign a Service Selection form during the application process, indicating that they have been informed of all approved providers within their region. In the Participant Rights Form, which is signed annually, there is a description of the right to choose and change waiver service providers, as requested by the waiver participant. The Service Coordinator is responsible for assuring that the waiver participant knows about his/her ability to choose or change waiver service providers and assist the waiver participant to do so. DOH has developed a user friendly process for changing waiver service providers.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

There is a multi-tiered approach to ensuring the quality of Service Plans. The first review will be conducted by the RRDSs of all Service Plans, developed at least every six months, at the request of the waiver participant or as needed. This review is to assure that waiver services are being utilized appropriately, maintain the waiver participant's health and welfare and are cost-effective. The second-tier intervention will be conducted by the QMS, who will review every Service Plan over $300 per day. DOH Waiver Management Staff and QMS will conduct a retrospective random sampling, on an annual basis, of at least ten-percent (10%) of all Service Plans in Year One, at least five-percent (5%) in Year Two and at least two-percent (2%) in Year Three to assure that Service Plans are being appropriately approved. The DOH reserves the right and responsibility to review any Service Plan presented to the waiver program.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as waiver participant needs change. Specify the minimum schedule for the review and update of the service plan:

O	Every three months or more frequently when necessary
X	Every six months or more frequently when necessary
O	Every twelve months or more frequently when necessary
O	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
X	Service Coordinator
X	Other (*specify):*
	Regional Resource Development Specialist

j. Fair Hearing. As specified in Appendix F, the State provides the opportunity for a Fair Hearing under 42 CFR Part 431, subpart E, to individuals who are denied the service(s) of their choice or provider(s) of their choice.

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and waiver participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Once the Service Plan has been approved by the RRDS, the Service Coordinator is responsible for monitoring the implementation of the Service Plan and the waiver participant's health and welfare. For the first six months of the Initial Service Plan (ISP) the Service Coordinator will have monthly face to face meetings with the waiver participant. After that time the Service Coordinator will have regular contacts with the waiver participant based on the frequency described in the approved Service Plan to assure that the services are meeting the waiver participant's needs and that the waiver participant is satisfied with the services being provided. A Team Meeting can be called at any time by the Service Coordinator or other providers of waiver or non-waiver services, and at the request of the waiver participant. The purpose of this Meeting is an opportunity to allow for collaboration among the service providers and the waiver participant regarding the waiver participant's current needs and to ensure the health and welfare of the waiver participant. A Team Meeting is required when the Service Plan is revised every six months.

In addition to this, the RRDSs are responsible for the review of every Service Plan, Revised Service Plan and Addendum to assure they are meeting the waiver participant's health and welfare and that they are cost-effective. Service Plans over $300.00 per day are then also reviewed by the QMS.

Service Coordinators assist waiver participants in developing Service Plans that include services from a variety of sources. The NHTD waiver is built on the premise that all waiver participants will first utilize available informal/natural supports, available non-Medicaid community-based services, available Medicaid State Plan services and, finally, NHTD waiver services. NHTD waiver services are utilized as a last resort to eliminate any gaps in assuring the participant's health and welfare in the community or when the NHTD waiver services are more effective than Medicaid State Plan services.

Once the Service Plan is developed, the Service Coordinator is then responsible for monitoring the implementation of the Service Plan, including waiver participant access to non-waiver services such as vocational services, physician services, home care services available through the Medicaid State Plan and other non-Medicaid community-based services. For example, the Service Coordinator is responsible for ensuring that the waiver participant obtains follow-up medical care, if needed, and that the waiver participant attends routine medical appointments.

The methodology used to monitor the Service Plans, which include informal/natural supports, non-Medicaid community-based services, Medicaid State Plan services and NHTD waiver services, includes the Service Coordinator collaborating with the waiver participant, other interested parties and service providers. For the first six months of the Initial Service Plan (ISP) the Service Coordinator will have monthly face to face meetings with the waiver participant. After that time, the Service Coordinator maintains regular contact with the waiver participant as indicated in the waiver participant's Service Plan. The Service Plan can be revised with an Addendum if needed, as a result of changes in the waiver participant's condition or situation. The RRDS can also meet, as needed, with the team to discuss the provision of services and will monitor Service Plans. The RRDS will report any major problems that affect a waiver participant's health and welfare in their quarterly report to DOH waiver management staff. The RRDS will also contact DOH waiver management staff and/or the QMS for technical assistance on major problems. Finally, the QMS retrospectively reviews a random sample of Service Plans. The QMS will report to DOH the information received from these monitoring processes and their analysis of their findings. This information will be compiled into a

centralized database in order to track trends, determine the level of intervention that needs to occur (i.e. at the provider, regional or statewide level) and develop best practices.

Another way that Service Plans are monitored is through the Participant Satisfaction Survey conducted by the QMS on an annual basis. As part of this survey, waiver participants will be asked if they actually received the services in their Service Plan and their experiences with the services. These results will be compiled and sent to DOH waiver management staff to evaluate for trends. In addition, each waiver service provider agency must conduct their own participant satisfaction survey to ascertain the experiences of the waiver participants that they serve. The Service Coordinator will work with the waiver participant to remedy any problems that are identified.

Monitoring of the Service Plan is also done through the Incident Reporting process. All Serious Reportable Incidents are reported to the Service Coordinator, the RRDS and the QMS. When a Serious Reportable Incident involves issues affecting the waiver participant's health, such as unplanned hospitalizations or medication errors or refusals, follow-up will include the Service Coordinator working with the waiver participant to review the Service Plan to see if an Addendum or Revised Service Plan is necessary. The RRDS will include data on Serious Reportable Incidents in their quarterly report to DOH waiver management staff.

As previously stated, when a problem arises, the Service Coordinator will work with the waiver participant to find an agreeable resolution. If an agreeable solution is not found, then a Team Meeting may be called to further discuss the issue. In addition, the waiver participant can contact the RRDS, QMS or DOH at any time to discuss this issue. If the issue is not resolved, then a Fair Hearing may be requested. If a service needs to be added, modified or deleted then an Addendum must be made. With every Addendum the waiver participant must sign a Plan of Protective Oversight.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and waiver participant health and welfare *may not provide* other direct waiver services to the waiver participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and waiver participant health and welfare *may provide* other direct waiver services to the waiver participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the waiver participant. *Specify*:
	All waiver participants have a choice of their waiver service providers. At anytime, the waiver participant can change their waiver service providers, including Service Coordinators. If a waiver participant chooses to change a waiver service provider, a Change of Provider form must be completed. On an annual basis, the waiver participant reviews and signs the Participant's Rights Form, which describes the right to choose and change providers as requested by the waiver participant. Waiver participants maintain a copy of the signed form. The safeguards previously described are implemented from the start of the ISP to assure the services are being provided according to the Service Plan. As stated above, every RRDS reviews every Service Plan. Other safeguards will include a Recordable Incident Report; a Serious Reportable Incident Report; a toll-free NHTD waiver Complaint Hotline; the provision of the waiver provider staff and their supervisor's, the RRDS, the QMS and DOH telephone numbers to

	the waiver participant; annual DOH surveys and audits, retrospective reviews by DOH and QMS and regional forums. Waiver participant satisfaction surveys are conducted by providers, reviewed by DOH upon survey. Any concerns are reported to DOH waiver management staff. In addition, the QMS conducts annual Participant Satisfaction Surveys. The Service Coordinator has the dual role of developing and monitoring the Service Plan. While the entity that employs the Service Coordinator may provide other direct waiver services, the Service Coordinator can only provide Service Coordination and is prohibited from providing other direct waiver services. In order to ensure monitoring is conducted in the best interest of the waiver participant there are checks and balances that are in place. These checks and balances are outlined in Appendix D-1-b. In addition, the RRDS provides oversight, technical assistance and reviews every Service Plan during the time of development and every six months at the time of revision. The QMS also reviews Service Plans that are over $300 a day and other Service Plans as necessary. DOH waiver management staff can also review any Service Plan, whether it be random or targeted.

Appendix E: Waiver participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the waiver participant direction opportunities specified below.*]

Applicability *(select one)*:

○	**Yes.** This waiver provides waiver participant direction opportunities. Complete the remainder of the Appendix.
X	**No.** This waiver does not provide waiver participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Waiver participant direction of services includes the waiver participant exercising decision-making authority over workers who provide services, a waiver participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences an especially strong commitment to waiver participant direction. Indicate whether this waiver should be considered for Independence Plus designation (select one):

○	**Yes.** The State requests that this waiver to be considered for Independence Plus designation.
○	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Waiver participant Direction. In no more than two pages, provide an overview of the opportunities for waiver participant direction in the waiver, including: (a) the nature of the opportunities afforded to waiver participants; (b) how waiver participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to waiver participant direction.

b. Waiver participant-Direction Opportunities. Specify the waiver participant-direction opportunities that are available in the waiver. *Select one:*

○	**Waiver participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the waiver participant (or the waiver participant's representative) has decision-making authority over the workers who provide waiver services. Either the waiver participant or an agency may function as the common law employer. Supports and protections are available for waiver participants who exercise this authority.
○	**Waiver participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the waiver participant (or the waiver participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for waiver participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both waiver participant-direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for waiver participants who exercise these authorities.

c. Availability of Waiver participant Direction by Type of Living Arrangement. *Check each that applies:*

☐	Waiver participant direction opportunities are available to waiver participants who live in their own personal home or the home of a family member.
☐	Waiver participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The waiver participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Waiver participant-Direction. Election of waiver participant-direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every waiver participant (or the waiver participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for waiver participants who decide not to direct their services.
○	The waiver is designed to offer waiver participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for waiver participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Waiver participant. Specify: (a) the information about the waiver participant direction opportunities (e.g., the benefits of waiver participant-direction, waiver participant responsibilities, and potential liabilities) that is provided to the waiver participant (or the waiver participant's representative) to inform decision-making concerning the election of waiver participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided.

f. Waiver participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○		The State does not provide for the direction of waiver services by a representative.
○		The State provides for the direction of waiver services by representatives. Specify the representatives who may direct waiver services: *(check each that applies)*:
	○	Waiver services may be directed by a legal representative of the waiver participant.
	○	Waiver services may be directed by a non-legal representative freely chosen by an adult waiver participant. Specify policies that apply regarding the direction of waiver services by waiver participant-appointed representatives, including safeguards to ensure that the representative works in the best interest of the individual:

g. Waiver participant-Directed Services. Specify the waiver participant-direction opportunity (or opportunities) available for each waiver participant-directed service specified in Appendix C-3. *(Check the opportunity or opportunities applicable for each service)*:

Waiver participant-Directed Waiver Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to waiver participant direction. A governmental entity or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

○	Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	☐ Private entities
○	Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled	
	as specified in Appendix C-3.	
○	FMS are provided as an administrative activity. Provide the following information:	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the waiver participant is the common law employer of direct support workers:
		☐ Assists waiver participant in verifying support worker citizenship status
		☐ Collects and processes timesheets of support workers
		☐ Processes payroll, withholding, filing and payment of applicable federal, state and

	local employment-related taxes and insurance
☐	Other *(specify):*

Supports furnished when the waiver participant exercises budget authority:

☐	Maintains a separate account for each waiver participant's waiver participant-directed budget
☐	Tracks and reports on income, disbursements and balances of waiver participant funds
☐	Processes and pays invoices for goods and services approved in the service plan
☐	Provides waiver participant with periodic reports of expenditures and the status of the waiver participant-directed budget
☐	Other services and supports *(specify)*:

Additional administrative functions/activities:

☐	Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
☐	Receives and disburses funds for the payment of waiver participant-directed services under an agreement with the Medicaid agency or operating agency
☐	Provides other entities specified by the State with periodic reports of expenditures and the status of the waiver participant-directed budget
☐	Other *(specify):*

iv. **Oversight of FMS Entities.** Specify the methods that are employed to (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

j. **Information and Assistance in Support of Waiver participant Direction.** In addition to financial management services, waiver participant direction is facilitated when information and assistance are available to support waiver participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Service Coordination Activity**. Information and assistance in support of waiver participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through* **Service Coordination** *for each waiver participant direction opportunity under the waiver:*

☐	**Waiver Service Coverage**. Information and assistance in support of waiver participant direction are provided through the waiver service coverage specified in Appendix C-3 that is entitled:
☐	**Administrative Activity**. Information and assistance in support of waiver participant direction are furnished as an administrative activity. *Specify the types of entities that furnish these supports, how the supports are procured and compensated; describe in detail the supports that are furnished in conjunction with each waiver participant direction opportunity under the waiver; and, the methods and frequency of assessing the performance of the entities that furnish these supports:*

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to waiver participants who direct their services. *Describe the nature of this independent advocacy and how waiver participants may access this advocacy*:
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Waiver participant Direction. Describe how the State accommodates a waiver participant who voluntarily terminates waiver participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and waiver participant health and welfare during the transition from waiver participant direction:

m. Involuntary Termination of Waiver participant Direction. Specify the circumstances when the State will involuntarily terminate a waiver participant's use of a waiver participant direction opportunity and require the use of alternative service delivery methods, including how continuity of services and waiver participant health and welfare is assured during the transition.

n. Goals for Waiver participant-Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable waiver participant-direction opportunity. Annually, the State will report to CMS the number of waiver participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Waiver participants**	**Number of Waiver participants**
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		

Year 5 (renewal only)		

Appendix E-2: Opportunities for Waiver participant-Direction

a. Waiver participant – Employer Authority

i. Waiver participant Employer Status. Specify the waiver participant's employer status under the waiver. *Check each that applies:*

☐	**Waiver participant/Co-Employer**. The waiver participant (or the waiver participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of waiver participant-selected staff and performs necessary payroll and human resources functions. Supports are available to assist the waiver participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of waiver participant-selected staff:
☐	**Waiver participant/Common Law Employer**. The waiver participant (or the waiver participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent serves as the waiver participant's agent in conducting payroll and other employer responsibilities that are required by Federal and State law. Supports are available to assist the waiver participant in conducting employer-related functions.

ii. Waiver participant Decision Making Authority. The waiver participant (or the waiver participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that waiver participants exercise*:

☐	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
☐	Hire staff
☐	Refer staff to employer agent
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	Specify additional staff qualifications based on waiver participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☐	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits within the State's limits
☐	Schedule staff
☐	Instruct and train staff in duties
☐	Supervise staff
☐	Evaluate staff performance

☐	Verify time worked by staff and approve time sheets
☐	Discharge staff or notify the co-employer of the need for substitute staff
☐	Other *(specify)*:

b. Waiver participant – Budget Authority

i. Waiver participant Decision Making Authority. When the waiver participant has budget authority, indicate the decision-making authority that the waiver participant may exercise over the budget. *Check all that apply***:**

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-4
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Waiver participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the waiver participant-directed budget for waiver goods and services over which the waiver participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each waiver participant. Information about these method(s) must be made publicly available.

iii. Informing Waiver participant of Budget Amount. Describe the process by which the State informs each waiver participant of the amount of the waiver participant-directed budget and the procedures by which the waiver participant may request an adjustment in the budget amount. In accordance with the procedures specified in Appendix F, the waiver participant is offered the opportunity to request a Fair Hearing when the waiver participant's request for an adjustment to the budget is denied or the amount of the budget is reduced.

iv. Waiver participant Exercise of Budget Flexibility. *Select one:*

○	The waiver participant has the authority to modify the services included in the waiver participant-directed budget without prior approval. Specify how changes in the waiver participant-directed budget are documented, including updating the service plan:
○	Modifications to the waiver participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for preventing the premature depletion of the waiver participant budget or address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for ensuring the implementation of these safeguards:

Appendix F: Waiver participant-Rights

Appendix F-1: Opportunity to Request a Fair Hearing

a. Opportunity for Fair Hearing. The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated.

b. Method for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. State laws, regulations, and policies referenced in the description are available through the operating or Medicaid agency.

During the initial face-to-face meeting between the RRDS and the potential waiver participant, the RRDS provides information regarding the Notice of Decision form, the Conference and the Fair Hearing processes. The Service Coordinator (SC) ensures that the potential waiver participant understands their rights as they proceed through the process for admission into the waiver program and throughout the duration of their participation. Notice of Decision authorizing participation in the waiver program is provided by the RRDS to the participant, which includes Fair Hearing rights.

When an adverse action occurs (e.g. when the RRDS denies, suspends, or discontinues a waiver participant's services) a Notice of Decision is sent to the potential or active waiver participant (or his/her legal guardian) by the RRDS which includes detailed, easy-to read instructions about the right to request a Conference and/or a Fair Hearing, and the process for applying for either. The participant/legal guardian is also informed that requesting a Conference is not a prerequisite/or substitute for a Fair Hearing. The RRDS provides a copy of the Notice of Decision to the Service Coordinator, who is responsible for reviewing the form with the participant and /or legal guardian to assure understanding of the right to request a Conference or Fair Hearing. In addition, the SC reviews information regarding the participant's right to continue services during the period while the participant's appeal is under consideration, as noted in the Notice of Decision. A copy of the Notice of Decision with the Conference and Fair Hearing information is kept in the individual's record maintained by the RRDS and Service Coordinator. This process conforms to the Federal and State statutory and regulatory provisions of the Medicaid program.

c. Notice(s). Appendix #1 to Appendix F-2 contains the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers waiver participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

X	The State operates an additional dispute resolution process *(complete Item b)*
○	Not applicable (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the State's additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a waiver participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available through the operating or Medicaid agency.

a) Department of Health, Office of Medicaid Management, Consumer and Local District Relations, Bureau of Long Term Care.

b) This Notice advises the waiver participant of the appeals process, if he/she believes the decision is wrong or if he/she does not understand the decision. The waiver participant is advised to contact DOH to request a Conference (an informal meeting with DOH). Disputes to be addressed include: Medicaid eligibility; NHTD waiver ineligibility; type and amount of services; choice and/or availability; refusal to sign the NHTD waiver application. A Conference with DOH may be requested at any time for the above listed reasons, but it is primarily used when there is a lack of agreement about the amount or type of services the RRDS approves. The waiver participant will be offered a Conference with the RRDS and the DOH, at the very earliest and convenient time available for all interested parties.

As part of the development of the Service Plan, waiver participants are advised to discuss any disputes with the Service Coordinator and the RRDS. If the dispute is not resolved at this level, the waiver participant may refer their concerns to the QMS and DOH. QMS and DOH can provide technical assistance, policy clarification or present alternative resolutions at any time during this process.

c) The waiver participant is advised that their right to a State Fair Hearing is preserved during the less formal Conference as described in the Notice of Decision forms. The waiver participant is advised that a request for a Fair Hearing must be submitted within 60 days of the date of the notice. The waiver participant has a right to request a Continuation of Benefits if a Fair Hearing is requested by the effective date stated in the Notice of Decision.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

X	**Yes.** The State operates a grievance/complaint system that affords waiver participants the opportunity to register grievances or complaints concerning the provision of services under this waiver.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DOH is responsible for assuring that a grievance complaint system is developed by each waiver service provider.

c. Description of System. Describe the grievance/complaint system, including (a) the types of grievances/complaints that waiver participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available through the operating or Medicaid agency.

DOH mandates that each waiver service provider develops and implements a policy for responding to complaints/grievances raised by the waiver participant. These policies must include procedures for filing the complaint/grievance, the process for investigation, and documentation of outcomes. In addition, any changes in agency policies and procedures related to the outcome of the investigation must be recorded and implemented. Each investigation must be conducted confidentially meeting the standards set by Health Insurance Portability and Accountability Act (HIPAA). Waiver participants are informed by the RRDS and Service Coordinator that filing a grievance/complaint is not a pre-requisite or substitute for a Conference or Fair Hearing and they may do so without jeopardizing the provision of services established in their service plan. Participant Rights ensure that participant's understand their right to submit complaints about any violation of rights and any concerns regarding services, to have complaints investigated and to be informed of the results of those investigations. Participant Rights Form is reviewed and signed yearly by the waiver participant.

A waiver participant may file a grievance/complaint through other mechanisms. These include providing a written or verbal complaint to any staff person associated with the waiver program. During the first phase of waiver program operation, DOH Waiver Management staff will field all complaint/grievance calls. During the second phase, it is anticipated that by the end of the first year of the waiver program operation DOH will establish and maintain the NHTD Complaint Hotline. Calls received through the Hotline will be transmitted geographically by the DOH Waiver Management staff and then submitted to the appropriate RRDS. The RRDS will then contact the provider allegedly involved, and the provider will investigate. If the RRDS is cited in the complaint, DOH Waiver Management staff will conduct the investigation. If the DOH Waiver Management staff and/or the RRDS deem the complaint to be at a significant level of concern, it may be turned into a Serious Reportable Incident.

A waiver participant may register grievances/complaints including the type, delivery and frequency of services, problematic issues regarding their RRDS, Service Coordinator, waiver service providers, QMS and general concerns about the waiver program.

To ensure that the waiver participant has proper access to the grievance/complaint process, the Service Coordinator must provide a list of phone numbers of their waiver service providers and their supervisors, RRDS, QMS, and DOH.

The waiver participant may register a verbal or written complaint at any time to the waiver provider, Service Coordinator, RRDS, QMS, and DOH. Within 72-hours, he/she will be contacted and updated regarding the investigational process.

All parts of the investigation are documented from intake through resolution. The QMS and DOH can provide policy clarification and/or present alternative resolutions at any time during this process. The QMS or DOH Waiver Management staff may meet with the waiver participant and anyone the waiver participant would like to have present, at the earliest and most convenient time for all interested parties. The investigation must be completed within a maximum of thirty (30) calendar days from receipt of the complaint. Written notification will be provided to the waiver participant advising them that the investigation has been completed and that the complaint has been resolved.

If the waiver participant is not satisfied with the decision, an appeal is made to the DOH. A response must be provided to the waiver participant within fifteen (15) business days from the date of the appeal.

Attachment #1 to Appendix F-1

Provide a copy of the notice or notices that are used to inform individuals of the opportunity to request a Fair Hearing.

Below is information regarding the Conference and Fair Hearing process.

Attachment 1 to Appendix F-1 contains the actual forms pertaining to:

Authorized/Reauthorized
Denial of Waiver Program
Suspension
Discontinuation

If you think this decision is wrong you can appeal. You can appeal two ways. You can do one or both of the following:

1. Ask for a meeting (conference) with the New York State Department of Health (DOH).
2. Ask for a State fair hearing with a State hearing officer from the New York State Office of Temporary and Disability Assistance.

CONFERENCE (Informal meeting with DOH)

If you think this decision was wrong or if you do not understand this decision, please call DOH at (518) 474-6580 to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. You are encouraged to do this even when you have asked for a Fair Hearing.

STATE FAIR HEARINGS

Right to a Fair Hearing: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) **Telephone**: You may call the statewide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
(2) **Fax**: Send a copy of this notice to fax number (518) 473-6735 **OR**
(3) **On-Line**: Complete and send the online request form at:
(4) https://www.otda.state.ny.us/oah/forms.asp **OR**
(5) **Write**: Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

For New York City waiver participants ONLY, you may also

(6) **Walk-In:** Bring a copy of this notice to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York

☐ I want a Fair Hearing. The Agency's action is wrong because:

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the effective date stated in this notice, you will continue to receive your Medical Assistance benefits unchanged until the Fair Hearing decision is issued. However, if you lose the Fair Hearing, you may have to pay back any Medical Assistance benefits you should not have received while you were waiting for the decision.

If you do not want your Medical Assistance benefits to continue until the decision is issued, you must tell the State when you call for a Fair Hearing, or if you send back this notice, check the box below:

☐ I do not want to continue my benefits until the Fair Hearing decision is issued.

Print Name:_____ Case Number: _____

Address: _____ Telephone: _____

Signature of client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

What to Expect at a Fair Hearing

The State will send you a notice which tells you when and where the Fair Hearing will be held.

At the hearing, you will have a chance to explain why you think the decision is wrong. You can bring a lawyer, a relative, or a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why the decision is wrong and a chance to give the hearing officer written papers which explain why the decision is wrong.

To help you explain at the hearing why you think the decision is wrong, you should bring any witnesses who can help you. You should also bring any papers you think may be of help to you. At the hearing, you and your lawyer or other representatives can ask questions of witnesses which may help your case.

LEGAL ASSISTANCE

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS

To help you get ready for the hearing, you have a right to look at your files. If you call or write to DOH, they will send you free copies of the documents from your file which will be given to the hearing officer at the Fair Hearing. Also, if you call or write to DOH, they will send you free copies of other documents from your file which you think you may need to prepare for your fair hearing.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION

If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call DOH at (518) 474-6580.

Appendix G: Waiver participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies referenced in this specification are available through the Medicaid agency or the operating agency (if applicable).

Type of incidents: Serious Reportable Incidents, Recordable Incidents

A. SERIOUS REPORTABLE INCIDENT is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her health and welfare or to their ability to remain in the community. These incidents include:

-Allegations of physical, sexual and psychological abuse, seclusion, unauthorized or inappropriate use of restraints, use of aversive conditioning, violation of civil rights, mistreatment, neglect and exploitation
-Missing person
-Death of a waiver participant
-Unplanned hospitalization
-Possible criminal action
-Medication error/refusal
-Medical treatment due to accident or injury
-Sensitive situation is any situation that does not fit within the above categories, which needs to be brought to the attention of the RRDS that would potentially threaten the waiver participant's health and welfare or ability to remain in the community, such as an admission into a substance abuse or psychiatric facility.

a. Follow up and Time Frame of a Serious Reportable Incident to DOH:

1. The waiver provider discovering that an alleged Serious Reportable Incident has occurred must report the alleged incident to the responsible RRDS within 2-hours of the discovery by telephone followed by fax or email of the DOH Serious Reportable Incident Initial Provider Report. A copy of this form is also sent to the Service Coordinator.
2. The reporting waiver provider is responsible for completing the DOH Serious Reportable Incident 24-hour Provider Report and sending it via fax or mail to the RRDS within 24-hours of discovering the incident. If the Service Coordinator is not the one reporting the incident, the Service Coordinator will receive a copy of this report within 24-hours of it being reported by the reporting agency. In addition, the Service Coordinator must notify the waiver participant or their legal guardian within 24-hours of receiving the report that the incident is being investigated. Other program or waiver providers are notified by the Service Coordinator when the evidence of injury or incident may impact services or the waiver provider. In case of a waiver participant's death, the reporting agency will also provide a copy of the completed form to DOH within 24-hours of reporting the death. The RRDS will assure DOH has received a copy of the report. The RRDS and QMS will keep an Incident Report database to be reported to DOH on a quarterly basis or as necessary, per

severity of incident. When it is deemed appropriate to contact Adult Protective Services (APS) as part of the investigation, the RRDS will assure this was done. In addition, waiver policy indicates notification to the police if any criminal action occurs. Any entity involved in the investigation process may initiate contact with APS or the police. All contacts with APS and/or the police must be documented as part of the investigation process.

3. Upon receipt of the DOH Serious Reportable Incident 24-hour Provider Report, the RRDS reviews it within 24-hours and completes the DOH Serious Reportable Incident RRDS Initial Response form, assigning an incident number to the case. The RRDS assigns responsibility for the investigation usually to the provider alleged to be involved in the incident. The DOH Serious Reportable Incident RRDS Initial Response form and the DOH Serious Reportable Incident 24-Hour Provider Report are forwarded by the RRDS to QMS, Service Coordinator, the investigating waiver provider and the discovering provider (if different from the investigating provider) by the RRDS. If the RRDS is concerned that the waiver provider involved in the investigation of the Serious Reportable Incident is not in a position to conduct an objective, thorough investigation, the RRDS has the discretion to assign another waiver provider to conduct the investigation.
4. The investigating waiver provider must designate at least one individual to be responsible for conducting a thorough and objective investigation. The investigator is required to have experience and/or training in conducting investigations. Those conducting the investigation may not be: directly involved in the incident; an individual whose testimony is incorporated in the investigation; or individuals who are the supervisor, supervisee, spouse, significant other or immediate family member of anyone involved in the investigation.
5. The investigating waiver provider is responsible for contacting their Serious Incident Review Committee to initiate their involvement in the investigation process.
6. Within one week of receiving the DOH Serious Reportable Incident 24-Hour Provider Report and the DOH Serious Reportable Incident RRDS Initial Response forms, the investigating waiver provider must submit a DOH Serious Reportable Incident Provider Follow Up Report to the RRDS and Service Coordinator. The RRDS then forwards the form to QMS.
7. Within thirty (30) days following receipt of the DOH Serious Reportable Incident 24-Hour Provider Report and the DOH Serious Reportable Incident RRDS Initial Response forms, the investigating provider must submit a DOH Serious Reportable Incident Provider Follow-Up Report to the RRDS for review which includes documentation from the waiver provider's Serious Incident Review Committee response to the investigation. The RRDS forwards the report to QMS.
8. Within two (2) weeks of receipt of the investigating provider's DOH Serious Reportable Incident Provider Follow-Up Report with the Serious Incident Review Committee's documentation, the RRDS will discuss the incident with QMS to determine whether the investigation is deemed closed or open for further investigation. The RRDS must complete the Serious Reportable Incident RRDS Status Report indicating this decision. This report is sent to QMS, Service Coordinator and the investigating waiver provider.
9. If the incident is considered to be open, continued follow-up and investigation by the investigating provider is expected. A Serious Reportable Incident Follow-Up Report must be submitted monthly by the anniversary date of the discovery of the incident by the investigating provider to the RRDS. These monthly reports will continue until corrective actions assure that the investigating waiver provider has put in place policy and procedures which will significantly decrease the probability of this type of incident recurring and the RRDS declares the incident closed. The RRDS will forward a copy of the report to QMS. Once the incident is deemed closed, the Serious Reportable Incident RRDS Status Report is

sent to QMS, Service Coordinator and investigating waiver provider.

10. The RRDS may request technical assistance/guidance from QMS at any step of this process based upon the severity and/or duration of time to determine a resolution.

b. Who must report a Serious Reportable Incident:

Any employee of a waiver provider witnessing any action or lack of action that may constitutes a Serious Reportable Incident as described above is responsible for initiating the process for investigation. It is understood that in some cases the employee may need to notify their supervisor and that the supervisor may be the person to notify the RRDS, QMS and the Service Coordinator. However, it still remains the responsibility of the employee that witnesses the incident to complete the Incident Reporting Form.

If no waiver provider employee witnessed the incident, the employee who first becomes aware of the incident must notify their supervisor upon discovery. The supervisor must notify the RRDS within two hours of the discovered alleged incident. The employee or their supervisor will initiate the DOH Incident Reporting Form and assure it is forwarded to the RRDS within 24-hours.

B. A RECORDABLE INCIDENT is defined as incidents that do not meet the level of severity as a Serious Reportable Incident but impacts the waiver participant's life in the community. Examples of Recordable Incidents are falls that do not require medical attention and minor difficulties in money management. These incidents must be reported, investigated and tracked within the provider agency.

a. Each waiver provider agency will have policies and procedures regarding Recordable Incidents including the following:
-title or position of the individual(s) responsible for implementing these policies;
-process for reporting, investigating and resolving Reportable Incidents within the agency
-process for identifying patterns of incidents involving a specific participant or staff within the agency that threaten the health and welfare of participants in general
-system for tracking the reporting, investigating and outcome of all Recordable Incidents and recommending action for changes in policy and procedures
-criteria used to determine when a Recordable Incident should be upgraded to a Serious Reportable Incident and reported to DOH.

DOH reserves the right to review Recordable Incident reports at any time.

This safeguard will be updated as needed and will be reported on the expected 373Q Report regarding any changes.

b. Waiver participant Training and Education. Describe how training and/or information is provided to waiver participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation and how waiver participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the waiver participant may have experienced abuse, neglect or exploitation.

The Service Coordinator will provide the waiver participant, their family or legal guardian information to identify actions described as abuse, neglect and exploitation and other types of serious reportable incidents along with the process for reporting any perceived or actual threat to his/her health or welfare or their ability to remain in the community. The Service Coordinator will

provide: the waiver participant, their family or legal representative with the Waiver Participant's Rights; a Waiver Contact list including the name, title, phone number and address of all providers, in addition to all information on how to contact the RRDS, QMS, DOH Waiver Management Staff; and the toll-free NHTD waiver Hotline when established.

The Service Coordinator will assist the waiver participant with completing the Plan of Protective Oversight.

The Service Coordinator will provide all of the above noted information to the waiver participant at the time of the development of the Initial Service Plan and annually, unless the waiver participant's health and welfare are noted as being at risk and additional education is necessary.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The entities that receive reports of critical events or incidents specified in G-1a include the Service Coordinator, the RRDS, QMS, the investigating agency and their Serious Incident Review Committee. If a death has occurred, DOH will also receive a copy. The waiver participant and/or legal guardian will receive notification that an investigation is being conducted. When it is deemed appropriate to contact Adult Protective Services (APS) or the police as part of the investigation, the RRDS will assure this was done. Any entity involved in the investigation may initiate contact with APS. All contacts with APS and/or the police must be documented as part of the investigation process

The reporting waiver provider must send notification to the local RRDS by telephone within 2 hours of discovery of the alleged incident followed by faxing or emailing of the DOH Serious Reportable Incident Initial Provider Report.

Within 24-hours of reporting the alleged serious incident, the reporting waiver provider completes a DOH Serious Reportable Incident 24-Hour Provider Report and sends a copy to the RRDS. The form must be faxed or sent via express mail by the reporting agency. In case of a waiver participant's death, DOH will also receive the the DOH Serious Reportable Incident 24-Hour Provider Report form within 24-hours of reporting the death. The RRDS will assure DOH has received a copy of the report.

The Service Coordinator, if not the reporting waiver provider, will receive a copy of the DOH Serious Reportable Incident 24-Hour Provider Report within 24-hours of the incident being reported. The Service Coordinator notifies the waiver participant or legal guardian within 24-hours of receipt of the report that an investigation is being conducted.

The Service Coordinator will notify other programs or waiver providers involved in the participant's service plan when the evidence of injury or incident may impact services or the waiver provider.

If the reporting waiver provider is not the agency involved in the investigation, the RRDS must notify the investigating waiver provider as soon as he/she receives notification of the incident.

Upon receipt of the DOH Serious Reportable Incident 24-Hour Provider Report, the RRDS has 24-hours to complete the RRDS Initial Response form, assigning an incident number to the case. This

incident number is to be used on all subsequent communications regarding the incident. The RRDS submits the DOH Serious Reportable Incident 24-hour Provider Report and the DOH Serious Reportable Incident RRDS Initial Response forms to QMS and the investigating waiver provider. In addition, the reporting provider receives a copy of the DOH Serious Reportable Incident RRDS Initial Response form.

If the RRDS is concerned that the waiver provider deemed responsible for investigating the Serious Reportable Incident is not in a position to conduct an objective, thorough investigation, the RRDS has the discretion to assign another waiver provider to conduct the investigation.

The investigating waiver provider is responsible for notifying their Serious Incident Review Committee that an investigation has been initiated and their involvement is required. The investigating waiver provider must designate at least one individual to be responsible for conducting a thorough and objective investigation. The investigator is required to have experience and/or training in conducting investigations. Those conducting the investigation may not be directly involved in the incident, an individual whose testimony is incorporated in the investigation, or individuals who are the supervisor, supervisee, spouse, significant other or immediate family member of anyone involved in the investigations.

Within one (1) week of receiving the DOH Serious Reportable Incident 24-Hour Provider Report and the DOH Serious Reportable Incident RRDS Initial Response forms, the investigating waiver provider submits a Serious Reportable Incident Follow-Up Report to the RRDS, who forwards a copy to the QMS.

Within thirty (30) days following receipt of the DOH Serious Reportable Incident 24-Hour Provider Report and the DOH Serious Reportable Incident RRDS Initial Response forms, the investigating waiver provider must submit the Serious Reportable Incident Follow-Up Provider Report to the RRDS, who then forwards the report to the QMS. In addition, a copy is sent to the Service Coordinator. This report must also include the recommendations of the agency's Serious Incident Review Committee.

Within two (2) weeks of receipt of the DOH Serious Reportable Incident Follow-Up Report the RRDS makes the decision to close the case or leave it open for further investigation following dialogue with QMS. The RRDS completes the DOH Serious Reportable Incident RRDS Status Report indicating that the case is closed or remains open with reasons why. A copy of the report is sent to the QMS, Service Coordinator and investigating provider

If the incident is considered to be open, continued follow-up and investigation by the investigating waiver provider is expected. A DOH Serious Reportable Incident Follow-Up Provider Report must be submitted by the investigating waiver provider to the RRDS monthly no later than on the anniversary date of the discovery of the incident. This monthly reporting will continue until corrective actions assure that the waiver provider has put in place policy and procedures which will significantly decrease the probability of this type of incident recurring and the RRDS has closed the incident following dialogue with QMS. A final DOH Serious Reportable Incident RRDS Status Report will be completed and sent to the QMS, Service Coordinator and investigating provider.

QMS may be asked by the RRDS to provide technical assistance/guidance at any step of this process.

Serious Incident Review Committee

The Serious Incident Review Committee, organized by each waiver provider, will meet at least quarterly and always within one-month of a report of a Serious Reportable Incident. The Committee will review all Serious Reportable Incidents to assure that incidents are appropriately reported, investigated and documented and that final recommendations are in line with the best clinical practice and in compliance with the guidelines of the NHTD waiver. The Committee also assures that the waiver provider's Serious Incident Reporting policies and procedures comply with DOH NHTD Incident Reporting Policies. This Committee will determine if necessary and appropriate corrective, preventive and/or disciplinary actions had been taken, develop recommendations for changes that may prevent or minimize recurrence of the incidents, and identify trends in Serious Reportable Incidents. In addition, the Committee will review all Recordable Incidents.

The Serious Incident Review Committee prepares an annual report that includes all Serious Reportable Incidents and Recordable Incidents reviewed by the Committee throughout the year. The report is submitted to the RRDS who sends the report to the QMS and DOH for review. This report will show congruity between the number of Serious Reportable Incident reports received by DOH and the number of reports claimed by the waiver provider. In addition, data from the report will assist DOH in identifying trends, and whether corrective, preventive and/or disciplinary action pertaining to identified outcomes was successfully implemented. Also, data from the report will be used to evaluate whether further waiver provider training and educational programs are needed and to determine if systemic actions need to be taken.

The RRDS provides a quarterly report to QMS and DOH of all Serious Reportable Incidents for their region containing documentation regarding trends, severity of incidents, the status and the outcome of the investigations. QMS reviews for regional trends and makes recommendations for needed interventions to the DOH. DOH reviews data against the expected goals of the RRDC contractual obligations. Additionally, DOH analyzes the data for state-wide trends that may warrant changes in the NHTD Waiver program. RRDS, QMS and DOH maintain close communication regarding the management of issues raised through investigations.

QMS has the authority to investigate the conduct, performance and/or alleged neglect of duties of administrators or employees of any waiver provider or individual serving as a waiver provider. This level of intervention occurs when there are concerns that the waiver provider has not followed the procedures of this policy. Findings are reported to DOH. If the waiver provider is found to be noncompliant with these policies, DOH will take appropriate action that may include terminating the Provider Agreement.

During survey of waiver providers, DOH will evaluate processes to assure the waiver providers have complied with recommended changes in policy/procedures. DOH may be called upon when there is concern regarding a particular waiver provider's practices. DOH reserves the right to review how successful a waiver provider has been in incorporating and utilizing any changes in the waiver provider's policy and procedure in regards to recommendations related to investigations.

DOH works cooperatively with other State agencies that provide services to individuals with disabilities, informing them when mutual providers experience significant or numerous Serious Reportable Incidents.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants.

DOH

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when state policy permits the use of restraints and/or restrictive interventions during the course of the provision of waiver services regardless of setting.

a. Applicability. *Select one:*

X	This Appendix is not applicable. The State does not permit the use of restraints or restrictive interventions *(do not complete the remaining items)*	
○	This Appendix applies. *Check each that applies:*	
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Service furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict waiver participant movement, waiver participant access to other individuals, locations or activities, restrict waiver participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to waiver participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does need not be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

X	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring waiver participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Waiver participants living in a private residence or Residential Programs for Adults must be monitored regarding their ability to self-administer medications. Upon admission to the waiver program, every six (6) months and as necessary, the Service Coordinator gathers information regarding the participant's ability to self-administer medications. If problems are identified, the waiver participant is referred to an appropriate service provider for an assessment and/or training and assistance to ensure safe management of the participant's medication. An appropriate service provider may include providers of Medicaid State Plan services, other local, state or federal program providers or a waiver service provider. In some instances informal supports may also be utilized. All waiver provider staff are trained to be competent to provide second line monitoring with a special emphasis on participant's who take behavior modifying medications. All waiver provider staff who provide billable services included in the Service Plan are responsible for reporting any cognitive, physical and/or behavioral changes to their supervisor or to the Service Coordinator, which may require intervention.

Residents residing in Residential Programs for Adults through the NYS Office of Mental Health (OMH) must follow OMH regulations. Supervision is provided to each resident concerning self-administration and storage of their medications by OMH residence staff. In addition, the NHTD waiver Service Coordinator will monitor the management of waiver participant's medication(s) upon admission to the waiver program, every six (6) months using a multidisciplinary team approach (participant, family, waiver providers, OMH residence staff and Service Coordinator), and as needed. Each individual OMH residence is responsible to train their staff on signs and symptoms associated with side effects including any behavioral changes that occur. The OMH residence staff reports any problems to the outpatient provider(s) responsible for medication reviews, prescription renewals and changes in medication. The Service Coordinator is kept informed of any changes in a participant's medication regime by the OMH residence staff.

Medication monitoring to waiver participants who are residents of licensed Adult Care Facilities (ACF), for example Adult Homes, must follow specific DOH regulations regarding medication management and medication assistance. Each resident capable of self-administration of medication shall be permitted to retain and self-administer medication provided that the resident's physician attests, in writing, that the resident is capable of self-

administration; and the resident keeps the ACF informed of all medications being taken, including name, route, dosage, frequency and any instructions including contraindications by the physician or pharmacy. Waiver participants living in an ACF who are in need of supervision and assistance with medication management, will be provided their medications by the ACF staff. The ACF staff must provide the waiver participant with the proper dosage of medication, frequency, dosage and route. The ACF staff must observe and record that the waiver participant took his/her medication at the time the medication is provided to the waiver participant. This record must also include the time the medication is provided to the waiver participant, and if there are any contraindications of the medications. All allergies are listed in the medication assistance record. This record is reviewed daily by the ACF staff that assists in this area and at any time there is a medication refill. The Service Coordinator will also monitor the management of waiver participant's medication upon admission to the waiver program, every six (6) months, and as needed.

The scope of monitoring is designed to focus on medication usage patterns. ACFs were provided with a manual designed by DOH to use as a guide in training staff who provide care to residents. DOH provided the manual during the "Medication Assistance Train the Trainer" training program. New ACF staff must complete a 40-hour training program, which includes medication assistance training for the personal care staff who assist with medication.

The operator is responsible for having policies and procedures in place for each area of medication management. These include: the acquisition of new and refilled medications including identifying the process and identification of the individual or staff position responsible for performing the tasks; the storage of medications; the assistance with preparation; the recording of ordered medication; matching the medication with the resident for whom it is prescribed; the disposal of discontinued, unused or expired medication; and quality assurance of medication management priorities including the practices of residents who self-administer without assistance.

Each facility has a case manager who is responsible for monitoring, observing and evaluating resident needs which include medication management. If any resident shows any significant change in behavioral status or (or adverse reactions to medications), the case manager arranges for the resident to receive medical attention from his/her own physician. ACFs are monitored through the DOH survey process every 12-18 months, usually at 12-month intervals but this may depend upon the severity of violations sited. Those facilities with the highest compliance status usually do not warrant more frequent visits.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that waiver participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

ACFs are surveyed by DOH yearly or every 18 months. DOH has specific regulatory interpretations for medication assistance in ACFs. The ACF is cited for violation if it does not have policies and procedures for medication assistance in place or they are not in agreement with existing standards. DOH requires that the ACF facilities develop or revise policies and procedures related to medication assistance as part of their corrective action. Each ACF is also responsible to provide Quality Assurance for medication management.

OMH has specific regulations for medication management for their residences and are responsible for oversight of all medication issues. OMH surveys residences using a multi-tier system, which is based on provider deficiencies. Greater deficiencies are associated with higher tiers which translates to more frequent survey visits.

RRDS and Service Coordinator educate staff of the OMH licensed residences regarding the waiver's policies and procedures. Each time the Service Coordinator visits with the waiver participant, he/she will assure communication occurs with OMH residence staff about waiver participant's status. Communications will allow for discussion regarding any potentially harmful practices or findings brought to the attention of the Service Coordinator by OMH residence staff.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

O	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee waiver participant self-administration of medications. *(complete the remaining items)*
X	Not applicable. (*do not complete the remaining items*)

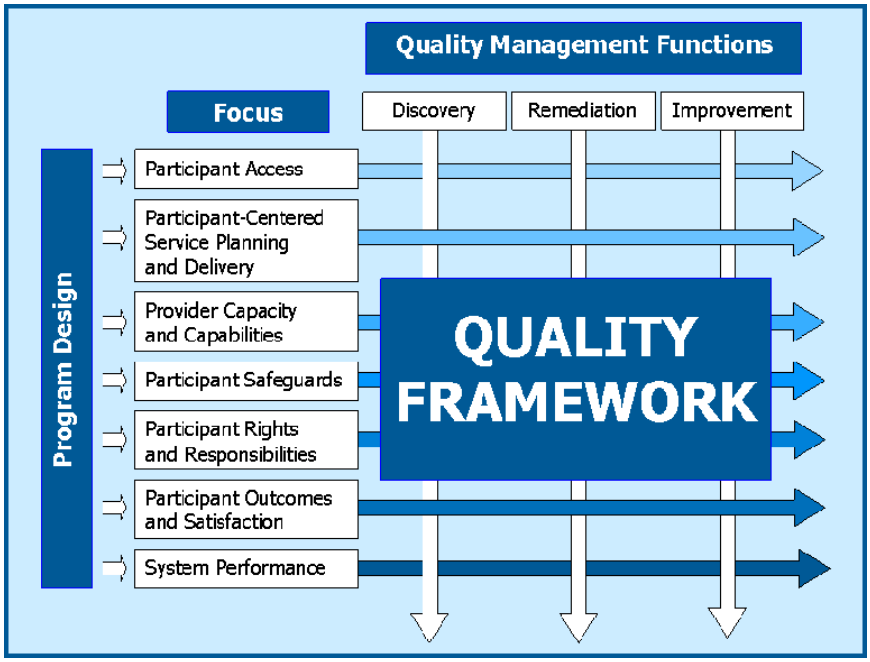
ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when waiver participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for the administration of medications to waiver participants are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for the administration of medications to waiver participants are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of waiver participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting the waiver assurances set forth in 42 CFR §441.301 and §441.302.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance is met.** For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The roles and responsibilities of the parties involved in measuring performance and making improvements must be specified. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants individuals, advocates, and service providers;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements must be specified. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of waiver participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the

specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

Quality Management Program

The Quality Management Program (QMP) combines quality assurance and quality improvement strategies to assure there is a system in place that continuously measures performance, identifies opportunities for improvement and monitors outcomes. Through a robust system of Discovery, information is gathered and analyzed to determine when there are problems, where the locus of the problem primarily lies, for example at provider or program level. Once appropriate action is taken to remedy the problem, the system of Discovery is used continuously to assure the proposed solution has been successful. Embracing the "participant-centered approach" to service provision, the Department of Health (DOH), Quality Management Specialists (QMS), Regional Resource Development Center (RRDC), Regional Resource Development Specialists (RRDS), Nurse Evaluators (NE), Service Coordinators (SC) and other provider agencies work collaboratively with waiver participants with a focus on his/her satisfaction and choice.

The QMP uses a five-level approach. Each level has a responsibility and an opportunity for identifying problems (Discovery), creating solutions at the provider level (Remediation) and assisting in changes in program policy (Improvement).

Level One is the waiver participant and natural supports. Waiver participants must have the tools needed to self-direct their services to the best of their capabilities. Waiver participants work with waiver providers to develop a plan that reflects personal goals and strategies to assure successful outcomes. The QMP assures that waiver participants receive ongoing support and monitoring of their health and welfare throughout their participation in the waiver program through: waiver participant education; Team Meetings; visits with the SC; access to all waiver providers including the NHTD Complaint Hotline; annual Participant Satisfaction Surveys; and timely response to concerns or Serious Reportable Incidents. Waiver participants play an active role in the Discovery process through communicating problems or issues to waiver providers. Working with waiver providers, waiver participants are part of the remediation process and provide input into solutions to assure successful outcomes.

Level Two is the SC and other waiver service providers. Providers must employ self-monitoring strategies that assure that the agency's policies and procedures regarding service provision to waiver participants meet the standards of the waiver program (Discovery). When problems are identified, waiver providers must evaluate whether the difficulty is staff-specific and/or related to provider-specific or programmatic policy and procedure. If the provider's own policy and procedures are the source of the problem, then the provider must assure that changes in policy and procedure are made that continue to support the waiver participants and maintain compliance with the standards of the waiver program. Using the NHTD Program Manual as a guide, each provider will have the tools needed to understand and measure the quality of service provision. These tools include: policies regarding Service Plan (SP) development; changing procedures; Participant Satisfaction Surveys; Complaint procedures and Serious Incident Reporting protocols; Serious Incident Review Committee; Team Meetings; and DOH surveys and audits.

Level Three is the RRDC which will employ the RRDS and NE. The RRDS acts as a gatekeeper and a point of entry for the NHTD waiver program. The RRDS has a lead role in the transition and

diversion of waiver participants. The RRDS is responsible for outreach, education and training, resource identification and referral, networking, assuring level of care, maintaining an aggregate budget, monitoring provider agencies, and approving SPs. The RRDS interviews all potential waiver providers, interviews all potential waiver participants, reviews every Application Packet and Revised SPs (RSP) and Addenda, and assures cost neutrality in the region. The RRDS compiles and reviews data collected from waiver providers and waiver participants in his/her region for quality assurance. The RRDS reviews provider investigations of Serious Reportable Incidents. Through these activities, the RRDS plays an essential role in the Discovery, Remediation and Improvement processes. The NE must be a Registered Nurse certified to conduct PRI/SCREEN assessments to evaluate, as necessary, new waiver participants and participants returning to the community following a significant medical event that may have altered the individual's cognitive or physical abilities. The NE will evaluate SPs at the direction of the RRDS, as appropriate. The NE will provide the results of his/her evaluation to the Service Coordinator selected by the waiver participant, as well as to other appropriate parties at the direction of the RRDS. The DOH contracts with the respective RRDCs will be effective at the start of the waiver.

Level Four is the QMS, another key resource in the waiver program. The QMS acts as a liaison between all waiver providers and DOH. The QMS supports the RRDS, providing technical assistance. Through analysis of obtained data, the QMS monitors for regional trends, works with the RRDS and waiver providers to remedy any issues discovered, and make recommendations to DOH for systemic improvements. The QMS reviews SPs over $300 per day to assure the health and welfare needs of the waiver participant are met in a cost-effective manner. As a Discovery method, the QMS assures Participant Satisfaction Surveys are conducted through face-to-face visits to assess waiver participant satisfaction. The DOH contracts with the respective QMSs will be effective at the start of the waiver.

Level Five is the DOH, who has the ultimate authority for administering, oversight and monitoring of the waiver program. DOH conducts ongoing review of Discovery information received through Serious Reportable Incidents, Regional Forums, RRDS, QMS, waiver providers, Fair Hearings, Hotline calls, financial audits, and DOH surveys. Data is analyzed for use in implementing remediation at the regional level and developing strategies for implementation on a state or system-wide level, as needed. DOH continuously monitors the outcomes of changes or improvements implemented to assure the standards of the waiver program are maintained throughout all levels of the QMP. DOH meets quarterly with the RRDSs and QMSs to identify concerns and examine remedial actions. DOH will initiate the development of Quality Advisory Board meetings designed to keep waiver participants, stakeholders, advocates, legislators and community representatives informed and involved in the process for change or improvement to the NHTD waiver program. DOH submits an annual report to CMS describing the ability of the waiver program to meet the assurances described in the application.

The following chart was created to illustrate how the assurances established by CMS will be met through DOH's Quality Management Program. This includes: using discovery as an activity to monitor performance through data collection and analysis; providing guidance to providers that better assists them in following the policies and procedures of the waiver and; developing strategies needed to assure improvements that support program standards. This is a continuous process that involves all levels to assure its success. Overall improvements are made at the State level based on

aggregation of the data and continuous dialog with all involved levels, facilitating changes in policies and standards on a provider, regional or statewide basis.

Information noted in this section can be found in more detail throughout other sections of this waiver application. The activities described were selected to meet CMS's review criteria.

Note: Each of the assurances under section H.1.a-f has been identified in the left column below. The five required CMS review criteria elements H.2 through H.5 have been identified and addressed in the right column under "Discovery, Remediation and Improvement".

Quality Assurances	
Assurances	**Discovery, Remediation, and Improvement**
H.1.a **Level of Care (LOC)**	
Waiver applicants for whom there is reasonable indication that services may be needed in the future are provided an individual LOC evaluation	1. The RRDS is responsible for assuring individuals are informed about the waiver application process including the need for a LOC evaluation. 2. If the RRDS has concerns about an individual meeting the LOC criteria, a LOC evaluation maybe completed by a qualified assessor prior to the development of the application packet by the SC. 3. As part of the application packet, the SC assures that a current PRI and SCREEN is/has been completed to evaluate LOC. 4. The SC submits the application packet, including the PRI and SCREEN, to the RRDS who reviews 100% of all applications received to assure compliance with eligibility criteria, including LOC. 5. If the validity of an LOC evaluation poses any concerns or questions for the RRDS, the NE will be asked to review the PRI and SCREEN and/or complete a new PRI and SCREEN for LOC determination. 6. If the individual's LOC evaluation does not meet the program criteria, the RRDS will assure that the individual is referred to other community resources either by the RRDS or SC. 7. The RRDS will track all referrals and include LOC determinations in quarterly reports to QMS and DOH. 8. The QMS will monitor quarterly reports for regional trends and suggest any additional training to the RRDS regarding the LOC process and waiver eligibility. 9. DOH will analyze quarterly and annual report data for trends that may warrant changes in policies and procedures on a statewide or regional level. 10. During an annual random retrospective record review of at least 10% in Year One, at least 5% in Year Two, and at least 2% in Year Three, QMS and DOH Waiver Management staff will evaluate the LOC evaluations.
The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver	1. Waiver participants are reevaluated at least annually for LOC through completion of the PRI and SCREEN, which are included in the RSP and more frequently depending on the waiver participant's needs. The RRDS reviews 100% of all RSPs to assure ongoing compliance with waiver standards regarding LOC determinations. 2. The SC will create and maintain a tracking system to assure timely LOC reevaluations.

	3. At a minimum of every six months, with the waiver participant present, the SC conducts a Team Meeting to review Service Plan (SP) for revision. If the team has concerns about the LOC, a new LOC evaluation will be completed. 4. During review of a RSP, the RRDS will inform the SC if an updated PRI and SCREEN is needed or if the PRI and SCREEN indicate an inappropriate LOC. The RRDS will maintain a system to track all LOC reevaluations to assure timeliness of submission. 5. The NE who will be a certified assessor will complete the updated PRI and SCREEN for LOC determination if there is no other certified assessor available or if the validity of the PRI and SCREEN is in question. 6. The RRDS submits quarterly reports to DOH Waiver Management staff and QMS containing data regarding all LOC reevaluations to demonstrate this assurance is being met. 7. The QMS will monitor quarterly reports for regional trends and suggest any additional training to the RRDS regarding the LOC process and waiver eligibility. 8. DOH will analyze quarterly data for trends that may warrant systemic changes on a statewide or regional level. 9. The QMS and DOH Waiver Management staff conducts an annual random retrospective record review of at least 10% of all LOC reevaluations included in the sample of SPs and RSPs in Year One, at least 5% in Year Two, and at least 2% in Year Three. Findings are evaluated for trends warranting any individual, regional or systemic changes or improvements. 10. DOH conducts record reviews during surveys of service coordination agencies to assure LOC determinations were timely and appropriate.
The processes and instruments described in the approved waiver are applied to LOC determinations	1. The NYS PRI and SCREEN are designated tools for documenting LOC and can only be completed by individuals properly trained and certified by the NYS DOH. The completed PRI and SCREEN is signed by the assessor, attesting to the validity of the assessment. If necessary, DOH has the ability to verify the credentials of the assessor completing the PRI and SCREEN. 2. The RRDS reviews 100% of all initial and subsequent PRI and SCREENS for timeliness and to be sure the instrument indicates the waiver participant does meet the LOC requirement. 3. Each RRDC will maintain a system to track the timeliness and appropriateness of all LOC evaluations/reevaluations as set in the NHTD Program Manual. 4. DOH Waiver Management staff will establish a centralized database within the first year of operation to gather information about all LOC evaluations to assure timeliness and appropriateness in meeting program standards.
The State monitors LOC decisions and takes action to address inappropriate level of care determinations	1. When the accuracy of LOC data is in question by the waiver participant, RRDS or SC, the NE will be utilized to review the data and, if necessary, will complete a new PRI and SCREEN. 2. The RRDS will ask the QMS to assist in the review of all LOC denials to evaluate circumstances of the denial, the appropriateness, and to monitor for regional trends.

	3. QMS will take action when inappropriate denials have been made (e.g. reinforce the RRDS training on the policies and protocols for LOC determinations). 4. If a reevaluation for LOC determines that the waiver participant is no longer eligible for waiver services and he/she disagrees with this decision, the NE may be asked to review the LOC evaluation. If the NE review confirms ineligibility, the RRDS, through a Notice of Decision, assures the waiver participant is informed of his/her right to a Conference and/or a Fair Hearing if he/she continues to disagree with the determination. The SC works with the waiver participant to ensure that they understand their rights. 5. Before being discontinued from the waiver program, the SC will make referrals for other services, if needed. The SC forwards the discharge plan to the RRDS for final approval. 6. The RRDS notifies the QMS and DOH of any Fair Hearings initiated due to LOC denials. 7. The RRDS will include all LOC denials in their quarterly reports data submitted to the QMS and DOH. 8. The QMS and DOH will analyze data received from RRDS quarterly reports for region-specific or statewide trends and will address issues with RRDSs accordingly.
Timelines:	All items listed in H.1.a will be in place by the start of the waiver program with the exception of the RRDS Annual Trend Analysis Report and the DOH centralized database which will be in place by the end of the first year of operation.
H.1.b **Individual SP (ISP)**	
Individual SP addresses all participant's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means	1. The RRDS meets every potential waiver participant prior to the development of the Initial SP. This provides the RRDS with information regarding the potential waiver participant's unique strengths and needs. This information is used when the RRDS reviews the Initial SP. 2. The SC works with the waiver participant to establish the Initial SP, RSP and any Addenda. The SP includes a range of services needed by the waiver participant including waiver and non-waiver services. The SP combines all services needed to address the waiver participant's health and welfare, personal goals and preferences and cultural traditions. 3. The waiver participant's signature on the SP signifies acceptance of the plan. 4. A Plan of Protective Oversight (PPO) is reviewed and completed with the waiver participant by the SC initially, at each RSP review, and with an Addendum, if changes to the PPO are indicated at this time. See Appendix D. 5. All initial and RSPs are forwarded to the RRDS for final review and approval. The RRDS conducts a comprehensive review of 100% of all SPs assuring the waiver participant's goals and preferences are recognized and the plan meets his/her health and welfare needs. 6. If the RRDS feels that the SP does not reflect the waiver participant's needs and goals, support health and welfare, or follow the program's policies, immediate corrective action will be requested from

	the SC before the SP is resubmitted for approval. 7. If a SP exceeds $300/day, the RRDS will send it to the QMS for review before approval. 8. Waiver providers will assess waiver participant satisfaction by conducting annual Participant Satisfaction Surveys and by investigating all complaints/grievances received. These surveys and complaints/grievances will be viewed by DOH during the survey process. 9. Any calls received by DOH, directly or through the NHTD Complaint Hotline, or issues raised during the annual Regional Forums regarding waiver participant SPs, will be directed to the RRDS for investigation and outcome which may include changes to the SP. 10. The QMS will assure Participant Satisfaction Surveys are conducted annually, analyzing data for waiver provider performance, SP implementation and regional trends. The outcomes of these surveys will be provided to DOH. When individual issues arise as a result of these interviews, the QMS will inform the RRDS to assure action is taken to remedy the situation. 11. The RRDS submits, as part of quarterly reports to DOH and QMS, data regarding the results of all initial, revised and Addenda to SPs reviewed (approved, denied, corrected) including the PPO, if indicated. 12. During annual random retrospective record review conducted by the QMSs and DOH all approved SPs will be reviewed at a rate of at least 10% in Year One, at least 5% in Year Two, and at least 2% in Year Three.
The State monitors SP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in SP development	1. The RRDS is responsible to review 100% of all SPs and Addenda to assure they are developed in accordance with waiver participant needs and goals, meet health and welfare, and reflect the policies and procedures of the waiver program. Any discrepancies in the SP are referred back to the SC by the RRDS for further assessment and/or modification before re-review by the RRDS for approval. 2. Each SP that is submitted to the RRDS for review and approval must be signed by the waiver participant to assure that the waiver participant agrees with the SP. 3. The RRDS assures that all SPs over $300/day are reviewed by QMS prior to final approval. 4. The RRDS submits data regarding SPs in their quarterly reports to the QMS and DOH Waiver Management staff. This data includes the percentage of SPs needing correction and the specific areas noted for correction. The QMS and DOH Waiver Management staff reviews the quarterly reports and responds to any noted issues or trends. Corrective action may include further training of SC and RRDS on the development of SPs. 5. The RRDS will compare all Serious Reportable Incidents against the SP to understand if a change in the type or amount of service is needed and works with the SC to assure that any immediate need for change in the SP are made at the waiver provider level. 6. The SC is responsible for assuring that a safe and effective SP is established with the waiver participant's involvement and support. Plans are formulated initially and revised at least every six months or

	with more frequent Addenda, as needed. The SC has a tracking system in place to guarantee the timeliness of SPs. 7. The SC is responsible for facilitating Team Meetings with the waiver participant to review the SP for revisions to ensure the waiver participant is involved and the waiver participant's preferences are included. 8. The SC submits the SP to the RRDS for review to assure the SP is appropriate and to avoid any lapse in service coverage. 9. DOH Waiver Management staff will monitor NHTD Complaint Hotline calls, gather data from the Regional Forums, complaints and annual Participant Satisfaction Surveys from QMS for trends or issues identified related to the SP. They will initiate an investigation to obtain further information regarding any identified issues. 10. DOH may place penalties on waiver providers for late submission of RSPs and/or Individual Service Reports. Penalties may include the discontinuance of the waiver provider agreement or a vendor hold, which prevents the waiver provider from accepting new waiver participants until the RSP is submitted and approved by the RRDS. In addition, the waiver provider may have to submit a plan of correction if the submission of late SPs is an ongoing problem. 11. DOH Waiver Management staff may request at any time RRDS or QMS review and/or a survey by DOH of any waiver provider where inadequacies in the SP development process are identified. 12. DOH Waiver Management staff and QMS conducts annual random retrospective reviews of at least 10% of all SPs in Year One, at least 5% in Year Two, and at least 2% in Year Three. DOH Waiver Management staff reserves the right to review SPs at any time.
SPs are updated/revised at least annually or when warranted by changes in the waiver participant's needs	1. The SC will assure that Team Meetings are held at least every six months with the waiver participant for the purpose of reviewing the SP for needed revisions. 2. An Addendum is used when there is a need for minor adjustments in the SP that are necessary to assure health and welfare. The Addendum is a short form that the RRDS can review and approve quickly. An RSP is used when there are major changes in the types and amounts of waiver services that are needed to assure health and welfare. In an emergency, the RRDS can contact DOH for technical assistance and provide immediate approval for services. 3. All RSP and Addenda must be approved by the RRDS assuring waiver participant needs, goals, and health and welfare are met. 4. A waiver participant may request a review of his/her SP at any time and the SC must comply with this request. If needed, a Team Meeting will be held with all appropriate persons in attendance. 5. In the event the outcome of an investigation of a Serious Reportable Incident, Recordable Incident or complaint leads to Addenda or revisions in the SP, the RRDS will assure that changes are implemented in a timely manner by waiver providers. 6. The SC and RRDS will track the submission and review of all SPs according to policy and procedure. 7. In the event SPs are delinquent, RRDS will notify DOH Waiver Management staff for technical assistance on how to proceed with the waiver provider.

Services are delivered in accordance with the SP, including in the type, scope, amount, duration, and frequency specified in the SP.	1. The SC will maintain regular contact, as described in the SP, with the waiver participant to discuss the delivery of services as approved in his/her SP. 2. The QMS and DOH Waiver Management staff conduct a random retrospective review of at least 10% of all SPs annually in Year One, at least 5% in Year Two, and at least 2% in Year Three to assure delivery of service according to the SP. 3. DOH Waiver Management staff evaluates a random retrospective review of documentation from SPs against data acquired through eMedNY to assure the type of service approved, and the frequency and duration have been appropriately delivered in accordance with the SP (refer to Appendix I). 4. During DOH surveys and audits of waiver providers, documentation is compared to the SP for accuracy to assure appropriate service delivery according to the SP. 5. Discrepancies between SPs and actual service utilization may be discovered through a range of methods including a random retrospective review of SPs, a comparison of SPs to claims data acquired through eMedNY, DOH surveys and audits of waiver providers, Hotline calls, waiver provider Participant Satisfaction Surveys, QMS Participant Satisfaction Surveys and Regional Forums regarding waiver participant experiences with provision of services. If problems are discovered, further investigation may be warranted. If it is found that services are not being delivered in accordance with the SP, DOH will take appropriate action which may include a vendor hold or termination of the Provider Agreement.
Participants are afforded choice between waiver services and institutional care	1. The RRDS is responsible for outreach and community education regarding the NHTD Waiver Program. 2. The RRDS interviews all potential waiver participants and offers them informed choice between community-based services versus institutional care. The RRDS, in quarterly reports to DOH, documents the number of potential waiver participants interviewed and the number of potential waiver participants who chose waiver services instead of institutionalization. 3. The RRDS documents that potential waiver participants are offered choice regarding waiver program and institutionalization by having the potential waiver participant sign the Freedom of Choice form during the initial phase of the application process. 4. The QMS and DOH waiver staff conducts an annual random retrospective review of at least 10% of waiver participant records in Year One, 5% in Year Two, and 2% in Year Three to assure that the Freedom of Choice form was completed and included in the Application Packet. 5. DOH Waiver Management staff conducts annual visits to the RRDS. These visits include review of all Freedom of Choice forms. 6. Potential waiver participants may contact the Complaint Hotline to express concerns about Freedom of Choice. DOH Waiver Management staff will monitor the Complaint Hotline and take appropriate action to assure that all potential waiver participants are offered the choice between waiver services and institutional care. 7. The QMS will conduct an annual Participant Satisfaction Survey to

	assure that waiver participants continue to be afforded choice between waiver services and institutional care. DOH Waiver Management staff will monitor these Surveys for trends related to freedom of choice and issue corrective action as necessary for remediation and improvement.
Participants are afforded choice between/among waiver services and providers	1. In the initial interview with the potential waiver participant, the RRDS explains the use of waiver services. 2. During the initial interview, the RRDS assures individuals are offered choice in selection of SC by providing a list of available SCs for selection. The potential waiver participant is encouraged to interview Service Coordinators prior to making a selection. Upon selection of a SC by the waiver participant, the RRDS assures the Service Coordination Selection form is completed and signed by the waiver participant and maintained in his/her record. 3. The waiver participant is informed during the initial interview with the RRDS and again by the SC that at any time he/she may request a change in waiver providers, including SCs and complete a "Change of Provider" form. The SC assures each waiver participant is given a list of available qualified waiver providers for selection which is attached to the Provider Selection form. Upon selection of waiver provider(s), the SC will assure the agency can accept the waiver participant. The SC assures that the Provider Selection form is completed signed by the waiver participant and maintained in his/her record. 4. The SC assures the waiver participant signs the SP indicating his/her acceptance of waiver providers and waiver services selected. 5. On an annual basis the SC assures that the waiver participant reviews and signs a Participant Rights and Responsibilities form which includes information regarding a waiver participant's right to choose between/among waiver services/providers. A copy is kept in the waiver participant's record and given to the waiver participant. 6. During data collection from annual QMS Participant Satisfaction Surveys, DOH management staff and QMS will note any negative responses regarding a waiver participant's right to choose waiver services and waiver providers. QMS will initiate actions to further investigate any response and report findings to DOH Waiver Management staff. DOH Waiver Management staff will impose penalties on waiver providers as necessary. 7. All waiver providers are responsible for conducting annual Participant Satisfaction Surveys containing questions about "choice". These surveys can be reviewed during DOH surveys and upon request by the RRDS, QMS and DOH Waiver Management staff. 8. DOH Waiver Management staff and the QMS will conduct annual random retrospective review of at least 10% of waiver participant records in Year One, 5% in Year Two, and 2% in Year Three to assure Provider Selection forms have been appropriately completed and to monitor trends that may warrant changes in protocol. 9. During annual Regional Forums DOH collects feedback from waiver participants regarding their choice of waiver services. DOH analyzes the information to determine if agency specific or system-wide improvements are needed.

Timelines:	All items listed in H.1.b. will be in place by the start of the waiver program with the exception of phase two of the NHTD Complaint Hotline, QMS Participant Satisfaction Survey and Regional Forums which will be in place by the end of the first year of operation.
H.1.c **Qualified Providers**	
The State verifies on a periodic basis that providers meet required licensing and/or certification standards and adhere to other standards prior to their furnishing waiver services. The State verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other State standards. The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements	1. NYS will only enter into Provider Agreements with agencies that meet the requirements for qualified staff. 2. Prior to approval, the RRDS conducts interviews of potential waiver providers which includes evaluation of employee resumes, ensuring employees meet the required qualifications. 3. Waiver providers are responsible for assuring their staff meets all qualification requirements set by the waiver program. 4. The RRDS submits recommendations to DOH regarding qualified providers. 5. Character and competency verification will be obtained through direct contact with other State agencies where applicable. 6. Certain waiver providers are mandated to obtain Criminal History Record reports from the U.S. Attorney General's Office for all prospective direct care and supervisory staff prior to employment other than those persons licensed under Title 8 of the Education law or Article 28-D of the Public Health Law (See Appendix C-2-a). 7. DOH Waiver Management staff will verify waiver provider qualifications including licensure or certification status if appropriate upon signed Provider Agreement. The waiver provider must report any subsequent change in status to DOH and/or RRDS/QMS. 8. DOH will survey all licensed and/or certified and non-licensed/non-certified waiver provider agencies within the first three-years of the onset of the waiver including a component on staff qualifications. 9. If a waiver provider is found not to have met licensure/certification requirements (including the mandatory statutes for Employee Criminal History Record checks) DOH reserves the right to place a vendor hold against the waiver provider and/or terminate the Provider Agreement. 10. A number of processes allow RRDSs, QMSs and DOH Waiver Management staff to develop a sense of competencies and provide a good understanding of waiver provider capabilities. These are: review of SPs, Serious Reportable Incident reports, annual waiver provider Incident Reports, training materials and staff interactions. 11. The RRDS will communicate specific concerns regarding waiver provider practices to DOH, leading to a DOH survey, audit or other possible further action as warranted. 12. DOH conducts surveys of waiver providers to assure they adhere to policies and procedures including Incident Reporting, Detailed Plans and Individual Service Reports, concerns/grievances and SPs. 13. During surveys of waiver providers, DOH will also evaluate to assure waiver provider employees meets job qualifications.
The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.	1. DOH Waiver Management staff provides training and educational programs for QMS, RRDS and NE. 2. In the Program Manual, DOH sets forth areas of training and competencies required for all staff of each waiver provider. 3. Waiver providers are responsible for maintaining ongoing training

	for their staff to assure that waiver compliance standards are met. 4. The RRDS provides training that includes Basic Orientation Training, Participant Rights, and service specific training programs to all approved waiver providers. The RRDS will maintain a list of all those trained and include this information in quarterly reports. 5. The RRDS will conduct 8-10 training programs per year to waiver providers in their region. 6. Documentation of training includes training curriculum, qualifications and name of trainer, attendance records, date and place of training, goals, and evaluation tools by waiver providers. 7. During DOH surveys and audits of waiver providers, documentation is reviewed to assure compliance with training standards. If compliance is not met, a plan of correction will be required and, if warranted, may lead to termination of the Provider Agreement. 8. DOH Waiver Management staff, QMS or RRDS may examine training curriculum or training records at any time.
Timelines:	All items listed in H.1.c. will be in place by the start of the waiver program.
H.1.d Health and Welfare	
There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.	1. The SC serves as a liaison between waiver providers, assuring ongoing communication occurs regarding issues pertinent to the waiver participant‘s health and welfare. 2. All waiver participants will be provided with a Contact Sheet listing SC, waiver providers, RRDS, QMS and DOH during the application phase by the SC. This information will be updated and provided to the waiver participant if any entity should change. These contacts allow for easier accessibility for waiver participants to communicate concerns regarding health and welfare. 3. The SC will facilitate Team Meetings with the waiver participant present at least every 6 months to review and revise the SP. 4. The RRDS will approve waiver participant applications, including the SP and PPO only if they set forth a plan to meet the waiver participant’s health and welfare needs. 5. The SC will conduct face-to-face visits with the waiver participant based on the SP or as requested by the waiver participant. 6. All waiver provider staff will be trained to observe and report changes in the waiver participant’s behavioral, physical and cognitive functioning and the process to follow if concerns arise. 7. Waiver providers will conduct a random sample of Participant Satisfaction Surveys annually including health and welfare issues. 8. DOH Waiver Management staff will monitor calls received from the DOH Hotline for trends. 9. All Serious Reportable Incident reports received will be investigated according to policy and procedure (see Section G-1). 10. Waiver provider trends, including frequency of Serious Reportable Incidents, are all monitored by the RRDS and QMS in their region. The remediation actions of the waiver provider are imperative to the decreased likelihood of repeated events. Results are submitted to DOH Waiver Management staff in quarterly reports.

	11. Waiver providers submit annual reports to the RRDS, QMS and DOH Waiver Management staff for further trend analysis of Serious Reportable Incidents. 12. DOH will initiate the development of a Quality Advisory Board by the end of the first year of operation to review statewide trends with a focus on health and welfare. 13. DOH manages system performance ongoing based on the outcome of trend analysis.
On an ongoing basis the State identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation	1. DOH provides each waiver provider with the policies and procedures for Serious Reportable Incidents including abuse, neglect and exploitation reporting, investigation and monitoring of outcomes (refer to section G-1). 2. Each waiver provider has a Serious Incident Review Committee responsible for investigating reports of Serious Reportable Incidents and Recordable incidents, assuring appropriate and immediate corrective or disciplinary action has been taken and preventive measures are in place. Waiver providers submit an annual report for review by the RRDS, QMS and DOH. DOH track trends and implements program changes as needed (refer to Appendix G-1). 3. Each waiver provider provides the RRDS, QMS and DOH with an annual report with noted trends of Serious Reportable Incidents and corrective actions taken. The QMS analyzes for regional trends and assists the RRDS with training and other activities needed to address concerns. This data is compiled and sent to DOH. 4. During surveys, DOH will review a waiver provider's policies and procedures regarding complaints, grievances protocols. 5. The QMS receives all Serious Reportable Incidents and forwards those of the greatest concern to DOH. 6. To measure system performance and to identify active or potential instances of abuse, neglect and/or exploitation, the QMS conducts a random sample of face-to-face Participant Satisfaction Surveys on an annual basis. 7. DOH reviews Participant Satisfaction Surveys conducted by the QMS, analyzes for trends and identifies any warranted programmatic changes. 8. The QMS may be asked for technical assistance by the RRDS.
Timelines:	All items listed in H.1.d. will be in place by the start of the waiver program with the exception of the Quality Advisory Board which DOH will begin development of by the end of the first year of operation.
H.1.e **Administrative Authority**	
The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state (if appropriate) and contracted entities	1. DOH maintains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by contracted entities. 2. DOH manages and oversees the performance of the contractors (QMS and RRDC) through annual random retrospective reviews of the SPs, Hotline calls, quarterly and annual reports, complaints/grievances, and annual on-site visits with the QMS, RRDC, RRDS and NE. At any time, DOH may determine that a decision by the QMS, RRDC, RRDS or NE does not reflect

	established policy, and will take action to assure that the waiver's policies and procedures are followed. 3. DOH has the final authority regarding discontinuance of a waiver participant from the waiver program and for termination of a Provider Agreement. 4. DOH Waiver Management staff anticipates open discussion with waiver participants, QMS, RRDS's, NE, waiver providers, LDSS and other community based organizations that serve people with disabilities and seniors to understand and evaluate the functioning of the contractor's staff. 5. DOH will maintain a database to gather, evaluate and monitor data collected from reports and survey results including Plan of Correction information for trend analysis and identification of the need for program changes or improvements. 6. DOH will attend annual Regional Forums with waiver participants, families, advocates and waiver providers to gather information pertinent to the performance of the contracted entities. 7. DOH will establish and maintain a toll-free NHTD Hotline for use by waiver participants and others by the end of the first year of operation. Until this Hotline is fully operational, DOH Waiver Management staff will field all complaint calls received. 8. DOH chairs RRDS/QMS Quarterly Meetings to review policies, network, present new policies/procedures, discuss regional trends and address waiver issues.
Timelines:	All items listed in H.1.e. will be in place by the start of the waiver program.
H.1.f **Financial Accountability**	
Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the SP, and properly billed by qualified waiver providers in accordance with the approved waiver.	1. The claims for federal financial participation for these waiver services are subject to the same policies and procedures that the DOH uses to claim federal financial participation for all other Medicaid services. 2. Each waiver provider is assigned a separate waiver provider identification number in eMedNY to assure that only qualified waiver providers are billing for services provided. Each waiver service is assigned a unique rate code. 3. Upon approval of the waiver participant's Initial SP, a waiver participant Exception Code, which is unique to the NHTD waiver, is placed in eMedNY to assure that claims are paid only for individuals who were enrolled in the waiver program on the date of service. 4. All Medicaid claims submitted to eMedNY are subject to a series of edits to ensure validation of data. These edits include: whether the waiver participant is Medicaid eligible; whether the individual was enrolled in the waiver program on the date of service; and whether the Service Providers are enrolled waiver providers in NYS. 5. The QMS and DOH will perform a random retrospective review of at least ten-percent (10%) of SPs in Year One; five-percent (5%) in Year Two; and two-percent (2%) in Year Three. DOH will compare the SPs reviewed with the claims for each waiver participant in this review to verify that the waiver services that have been rendered to waiver participants are authorized in the SP. Any discrepancies will

	be referred to the Office of the Medicaid Inspector General (OMIG). An automated database will be developed within three years to facilitate and support this process. 6. OMIG is responsible for the Department of Health's duties as the single state agency for the administration of the Medicaid program in New York State with respect to fraud, waste and abuse. The responsibilities of the OMIG include, among other responsibilities, the Medicaid audit function. Nursing Home Transition and Diversion waiver providers will be audited by the OMIG as part of the agency's fiscal audit plan. The frequency of audit of waiver providers will be dictated by overall audit demands and audit resources available to the OMIG. The DOH Waiver Management staff, QMS, and/or the RRDS may also recommend waiver providers to be audited and reviewed. Upon completion of each such audit, final audit reports will be written disclosing deficiencies pertaining to claiming, record keeping and provision of service. These final audit reports will be sent to the waiver provider with a copy provided to DOH Waiver Management staff. Based upon the OMIG audits, waiver providers' overall performance and financial controls can be evaluated. 7. The QMS will conduct Participant Satisfaction Surveys to ask waiver participants about their experiences with the services they have received and whether they have received the services that had been authorized in their SP. Responses will be shared with the RRDS and DOH Waiver Management staff who may request a financial audit of the waiver providers if there are areas of concern. 8. Based on DOH surveys of waiver providers, a financial audit may be triggered if areas of concern are identified. 9. To ensure that providers of Environmental Modifications, Assistive Technology, Community Transitional Services and Moving Assistance are billing properly, they are required to submit projected cost estimates and actual costs to the Service Coordinator. Upon financial audit of these providers, DOH will ensure that the claim amount is the same as the amount that was approved. 10. As with any Medicaid service, the costs of waiver services that are the responsibility of a third party must be paid by that third party. If a waiver participant has a third-party insurance coverage, he/she is required to inform the Local Department of Social Services of that coverage. 11. Waiver service billing is the same as all Medicaid billing. Claims will be subject to the same adjudication process, which involves prepayment edits for third party billing. 12. If a waiver participant has third party coverage in the system and a waiver provider tries to submit a bill to Medicaid prior to billing the third party, an edit will prevent the waiver provider from receiving payment. 13. If it was found that a claim was paid prior to the input of third party insurance information, the State will pursue retroactive recovery of funds from the potentially liable third party insurance. 14. The Explanation of Medical Benefits (EOMB) process is designed to inform waiver participants of services provided to them according to Medicaid records, and seek to verify that services billed by waiver

	providers were actually delivered. 15. eMedNY provides waiver participants with EOMBs and instructions to be used as a means of communicating any discrepancies as it relates to the services billed for by the waiver providers. The forms are returned directly to the Department of Health EOMB unit. 16. EOMBs can be produced for all, or for a random sample of waiver participants who received services. They can also be produced for specific waiver participants, waiver participants who received services from a specified waiver provider, or waiver participants receiving services related to a specified procedure or formulary code. The population of waiver participants who receive EOMBs is dictated by a set of user specified criteria. The maximum number that will be produced for a month is limited to 5,000 EOMBs.
Timelines:	All items listed in H.1.f. will be in place by the start of the waiver program with the exception of an automated database which will be established by the third year of operation.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that is conducted by the state to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits that are conducted; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available through the Medicaid agency or the other waiver operating agency (if applicable).

(a) DOH requirements concerning the independent audit of provider agencies

DOH is the State agency responsible for monitoring payments made under the NYS Medicaid Program. As part of this responsibility, the Department's Office of Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the eMedNY provider manuals.

18 NYCRR 517.3(b)(2) states, "All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Medicaid Fraud Control Unit or DOH for audit and review. . . ."

To ensure the integrity of provider claims for Medicaid payment of waiver services, the OMIG will conduct audits of waiver providers as part of the agency's fiscal audit plan. All waiver providers are subject to audits performed by the OMIG. The frequency of audit of waiver providers will be dictated by overall audit demands and audit resources available to the OMIG. These providers will be targeted via Data Warehouse (eMedNY) monitoring and provider profiling which will identify claiming patterns that appear suspicious or aberrant. The DOH waiver management staff, Quality Management Specialist, and/or the Regional Resource Development Specialist may also recommend providers to be audited and reviewed.

As with any Medicaid service, the costs of waiver services that are the responsibility of a third party must be paid by that third party. If a waiver participant has a third-party insurance coverage, he/she is required to inform the Local Department of Social Services of that coverage. Waiver service billing is the same as all Medicaid billing. Claims will be subject to the same adjudication process, which involves prepayment edits for third party billing.

If a waiver participant has third party coverage in the system and a provider tries to submit a bill to Medicaid prior to billing the third party, an edit will prevent the provider from receiving payment.

If it was found that a claim was paid prior to the input of third party insurance information, the State will pursue retroactive recovery of funds from the potentially liable third party insurance.

Under the provisions of the Single Audit Act as amended by the Single Audit Act Amendments of 1996, the New York State Division of Budget contracts with an independent entity, Toski et al, to conduct the independent audit of state agencies, including the Department of Health and its waiver programs.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services where the same method is employed.

There are several methods employed to determine provider rates for the waiver services. While different methods are utilized, waiver payment rates are all sufficient to enlist enough qualified waiver providers.

With the exception of non-medical payments (such as Community Transitional Services, Assistive Technology, Environmental Modifications and Moving Assistance), all rates are established by maintaining a state established fee-for-service schedule and include regional adjustment factors.

The rates for Service Coordination, Community Integration Counseling, Home and Community Support Services, Independent Living Skills Training, Nutritional Counseling/Educational Services, Peer Mentoring, Positive Behavioral Interventions and Supports, Wellness Counseling Service, Respiratory Therapy, Respite Services and Structured Day Program are based on cost-reports that include the costs of labor, administration and overhead with adjustments for utilization factors. The rate for Congregate and Home Delivered Meals is based on historical costs for materials, labor, administration and overhead. The rates for Assistive Technology, Community Transitional Services, Environmental Modification Services and Moving Assistance are based on actual costs plus an administrative fee. DOH has assigned separate rate codes for amount of dollars for each of these services to track the amount/cost of each service that is provided. The rate codes are one-dollar ($1.00), ten-dollars ($10.00), one-hundred dollars ($100.00) and one-thousand dollars ($1000.00) per unit. This allows the waiver provider to bill, through the eMedNY system, the specific number of units which reflects the cost for these services. The rate for Home Visits by Medical Personnel is based on historical reimbursement from Medicare. The NYS Division of Budget and DOH are responsible for establishing a reimbursement rate for each waiver service.

[NOTE: As discussed with CMS, the RRDCs are an administrative cost for DOH and are compensated as contractors. The costs for RRDCs are not part of the rate setting process.]

There are several means for the public to make comment on the rate methodology. Prior to submitting the application for the NHTD waiver to CMS, a Request for Information (RFI) was sent to key stakeholders throughout New York State asking for their input about the design of the waiver. Included in this RFI were questions about rate methodologies. DOH received comments regarding the importance of establishing rates that reflected the regional differences within the state and have incorporated their concerns into the methodology. The rate methodology used for the vast majority of NHTD waiver services are based on other waiver programs that offer the same services and have had sufficient qualified providers so as to provide choice to waiver participants. The state continues to have a dialogue with potential NHTD waiver providers regarding rate determination methods. Currently, DOH is working with an Advisory Board consisting of state agency representatives, provider associations and advocates for people with disabilities and seniors to examine potential barriers to implementation of the NHTD waiver including the adequate rate determination methods.
Rate information is made available to waiver participants in their Service Plans. Each Service Plan describes the frequency and duration of each service, the annual amount of units, the rate per unit

and the total annual cost of each service.
The Explanation of Medical Benefits (EOMB) process is designed to inform participants of services provided to them according to Medicaid records, and seek to verify that services billed by providers were actually delivered. eMedNY provides waiver participants with EOMBs and instructions to be used as a means of communicating any discrepancies as it relates to the services billed by the waiver providers. EOMBs can be produced for all, or for a random sample of participants who received services. They can also be produced for specific participants, participants who received services from a specified provider, or participants receiving services related to a specified procedure or formulary code. The population of participants who receive EOMBs is dictated by a set of user specified criteria. The maximum number that will be produced for a month is limited to 5,000 EOMBs for New York State Medicaid recipients.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The flow of billing goes from the waiver provider directly to the state's claims processing system, eMedNY. In the eMedNY system, the reimbursement for the services provided are tested against whether the waiver service was: provided to a Medicaid recipient who has been approved for this waiver, whether it has the right rate code and whether the waiver provider has been approved to provide the billed service.

The Medicaid provider is responsible for ensuring the accuracy of appropriate Medicaid data, such as the Medicaid provider ID, Medicaid recipient ID, that the service was provided to an approved waiver participant and the rate code for the services provided.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certify public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
X	**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the waiver participant's approved service plan; and, (c) the services were provided:

When the payment claim is submitted to eMedNY there are a series of edits performed that ensures the validation of the data. Some of the edits include: whether the waiver participant is Medicaid eligible; whether the individual was enrolled in the waiver program; and, whether the Service Providers are enrolled waiver service providers in NYS. DOH confirms that the edit test to ensure that a participant is eligible for waiver services will also verify that the participant was eligible on the date the service was provided. In addition, DOH confirms that all waiver claims paid through eMedNY will be subject to all the common payment integrity edit tests, as well as those specific to waiver transactions.

Retrospective reviews of at least ten-percent (10%) of Service Plans in Year One; at least five percent (5%) in Year Two; and at least two percent (2%) in Year Three will be compared with the claims for each waiver participant in this review. This review will focus on whether the services provided were part of the approved Service Plan and whether the amount of services were prior authorized. An automated database will be developed within three years to facilitate and support this process. In addition, validation of services provided will occur through various means including provider audits and the Participant Satisfaction Survey process.

In addition, the Explanation of Medical Benefits (EOMB) process is designed to verify with waiver participants that services billed by providers were actually delivered. eMedNY provides waiver participants with EOMBs and instructions to be used as a means of communicating any discrepancies as it relates to the services billed by the waiver providers. EOMBs can be produced for all, or for a random sample of participants who received services. They can also be produced for specific participants, participants who received services from a specified provider, or participants receiving services related to a specified procedure or formulary code. The population of participants who receive EOMBs is dictated by a set of user specified criteria. The maximum number that will be produced for a month is limited to 5,000 EOMBs for New York State Medicaid recipients.

To ensure that claims will meet the essential test that billed waiver services have actually been provided to waiver participants, DOH conducts waiver provider audits to verify that all Medicaid claims for reimbursement are supported with a record of the services provided. The record includes:

- Name of participant;
- Date of Service;
- Staff performing the activity and time and attendance records;
- The start and end time of each session;
- A description of the activities performed during the session; and
- The participant's service goal plans that are being worked on and the participant's progress toward attaining those goals.

Furthermore, as part of the claim submission process, providers must sign a Claim Certification Statement which includes certification that services were furnished and records pertaining to services will be kept for a minimum of six years.

Another way that DOH validates that billed services were actually provided to waiver participants is through the Participant Satisfaction Survey by the QMS. During this Survey, participants are asked about their experiences with the services that they have received. Responses to the Survey are shared with the RRDS and DOH waiver management staff. DOH waiver management staff will follow up on areas of concerns and may request a financial audit to verify the validity of billed services.

Non-medical payments (such as Community Transitional Services, Assistive Technology purchases, Environmental Modifications, Moving Assistance, etc.) will also be processed in eMedNY. These services do not fit into the traditional rate setting process. Each specific payment will be based on the tasks performed or the equipment or parts provided. DOH has instituted a variety of mechanisms to ensure that claim amounts are accurate and valid. DOH has assigned separate rate codes for amount of dollars for each of these services to track the amount/cost of each service that is provided. The rate codes are one-dollar ($1.00), ten-dollars ($10.00), one-hundred dollars ($100.00) and one-thousand dollars ($1000.00) per unit. This allows the waiver provider to bill the specific number of units which reflects the cost for these services.

In addition, for Environmental Modifications, Assistive Technology purchases, Community Transitional Services and Moving Assistance, the Service Coordinator will receive projected cost estimates and the actual costs to ensure that these costs are compatible. If there is a ten-percent (10%) or greater difference between the projected and actual costs, DOH will require an Addendum to the Service Plan to justify the increase. Upon financial audit of the provider, DOH will ensure that the claim amount is the same as the actual cost amount. In addition, as with any waiver service, all providers of Environmental Modifications, Assistive Technology, Community Transitional Services and Moving Assistance are enrolled NHTD waiver providers, thus subject to financial audits by DOH. All NHTD waiver service providers are responsible for keeping records sufficient to substantiate any Medicaid claims. These providers are audited on the accuracy and validity of such records to ensure that claim amounts are accurate and valid.

Both Community Transitional Services and Moving Assistance are billed through a Service Coordination agency chosen by the waiver participant. The Service Coordination agency must keep receipts for services rendered as part of their record keeping requirements. Through a survey or audit, DOH will examine the records of the Service Coordination agency to confirm that the receipts are present, and that the claim was accurate and valid based on the documentation of expenditures in the waiver participant's file.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

X	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services for which payment is not made through an approved MMIS; (b) the process for making such payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements. (*check each that applies*):

☐	The Medicaid agency makes payments directly to providers of waiver services.
X	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers through the use of a limited fiscal agent that functions only to pay waiver claims. Specify the limited fiscal agent, the functions that the limited fiscal agent performs in paying waiver claims and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for their provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services, the services that the public providers furnish, and whether the amount of the payment to public providers differs from the amount paid to private providers of the same services: *Complete item I-3-e.*
X	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

X	No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
O	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

X	Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
	Any agency that qualifies as governmental such as, SONYMA and the Dormitory Authority.
O	The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

O	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that waiver participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with PIHPs or PAHPs. *Select one:*

○	The State contracts with prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Waiver participants may *voluntarily* elect to receive *waiver* and other services through such prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Waiver participants are required to obtain *waiver* and other services through a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
X	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended as CPEs, as indicated in Item I-2-c:
	The General Fund (state tax revenue supported) state share for Medicaid is also appropriated in the NYS Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Children and Family Services, Office of Alcoholism and Substance Abuse Services, and State Education Department budgets. Funds are transferred from these agencies, upon approval from the NYS Director of Budget, to the Department of Health using the certificate of approval process (funding control mechanism specified in the State Finance Law, or through journal transfers, to the Department of Health (DOH).
X	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended as CPEs, as indicated in I-2- c:
	Medicaid State share is also provided through appropriations in DOH for funds (net of any federal share) received from drug rebates, audit recoveries and refunds, and third party recoveries; assessments on nursing home and hospital gross revenue receipts; and Health Care Reform Act (HCRA) revenues. Appropriations in OMRDD for the Mental Hygiene Patient Income Account and in OMH for HCRA also fund the state share of Medicaid and are transferred to DOH.

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

X	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended as CPEs, as specified in Item I-2- c:
	Counties in New York State and the City of New York have the authority to levy taxes and other revenues. These local entities may raise revenue in a variety of ways including taxes, surcharges and user fees. The State, through a state/county agreement, has an established system by which local entities are notified at regular intervals of the local share of Medicaid expenditures for those individuals for which they are fiscally responsible. In turn, the local entities remit payment of these expenditures directly to the State.

☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended as CPEs, as specified in Item I-2- c:
☐	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the sources of funds listed in items (a) or (b) for the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

X	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
	The State utilizes revenue from the following health provider tax programs to assist in financing its overall health care delivery system: • Surcharges on net patient services revenue for certain hospitals and comprehensive clinics • An assessment on general hospitals' gross inpatient hospital revenue • An assessment on certain hospitals' gross receipts for patient care services and other operating revenue • An assessment on certain nursing homes' gross receipts for patient care services and other operating revenue
☐	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the personal residence of the individual. (*Do not complete the remainder of this part*).
X	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete the next item*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Rates for waiver services are calculated on a statewide basis, with consideration made for regional differences in market basket costs. Rates are the same for a service regardless of type of living arrangements of the waiver participant. Thus, the provision of a service in a waiver participant's home will be the same as when the same service is provided in an Adult Home in the same region. There is no consideration of the cost of room and board in developing the rates.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the waiver participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:
X	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the waiver participant.

APPENDIX I-7: Waiver participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon waiver participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon waiver participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Waiver participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-b-iii and the groups for whom such charges are excluded. The groups of waiver participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of waiver participants subject to cost-sharing and the groups who are excluded (groups of waiver participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:			Nursing Facility				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	19,841	12,780	32,621	31,500	1,260	32,760	139
2	25,759	18,034	43,793	44,450	1,778	46,228	2,435
3	27,435	19,383	46,818	47,775	1,911	49,686	2,868
4							
5							

*** Please note: as per CMS direction the State has in each year multiplied the projected daily cost for all factors by the projected number of waiver days.**

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Waiver participants Served. Enter the total number of unduplicated waiver participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated waiver participants for each level of care:

Table J-2-a: Unduplicated Waiver participants

Waiver Year	Total Number Unduplicated Number of Waiver participants (From Item B-3-a)	Distribution of Unduplicated Waiver participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	1000		
Year 2	2500		
Year 3	5000		
Year 4 (renewal only)			
Year 5 (renewal only)			

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by waiver participants in Item J-2-d.

It is expected that there will be a steady, consistent flow of waiver participants for each of the initial three years. Therefore, each new waiver participant will average half a year, or six months, on the waiver during their first year. In subsequent years, it is expected that each waiver participant will spend a full calendar year on the waiver. This was the basis for the calculation of average length of stay on the waiver.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D, the projected cost of waiver services for approved waiver participants, was calculated using different means. Historical costs for services in this waiver that are also included in the Home and Community-Based Service Waiver for Individuals with a Traumatic Brain Injury are based on the actual usage of those waiver services, specifically the percentage of waiver participants using the service and the average usage. The 372 report submitted to CMS for the year 4/1/04-3/31/05 was used. These services include:
Service Coordination
Independent Living Skills Training
Structured Day Program
Intensive Behavioral Program (called Positive Behavioral Interventions and Supports in the NHTD waiver)
Community Integration Counseling
Home and Community Support Services
Environmental Modifications
Special Medical Equipment and Supplies (called Assistive Technology in the NHTD waiver)
Respite

This same method was used to determine the expected utilization of the services in this waiver that have also been available through the Long Term Home Health Care Program. The 372 report submitted to CMS for the year January 1, 2004 through December 31, 2004 was used. These services include:
Congregate and Home Delivered Meals
Moving Assistance
Nutritional Counseling/Educational Services
Respiratory Therapy.

The 372 report information was used as a starting point, with variations of projected use of the service based: on the differences between the population to be served and those served in the existing waivers; the availability of other waiver services included in this waiver; and the anticipated impact of the differences in the management structure of this waiver.

For those services which are going to be used for the first time in a waiver program, projections were based on a variety of factors, particularly the expected characteristics of the waiver participants and the availability of similar services reimbursable through other payors. These services include:
Home Visits by Medical Personnel
Wellness Counseling Services
Peer Mentoring

For Community Transition Services, the projected use was based on the concept that this waiver will equally serve individuals who are transitioning from, or being diverted from nursing home placement.

The projections for Home and Community Support Services(HCSS) and Positive Behavioral Interventions and Supports(PBIS) reflect expected significant differences between the participants in TBI waiver and those to be served under the NHTD waiver. In the TBI waiver, all participants, by nature of their diagnosis, had cognitive deficit, which resulted in the need for the oversight and supervision provided by HCSS; although many participants in the NHTD waiver will have cognitive deficits, there will also be a considerable number of participants who will not require oversight and supervision. Also, a significant majority of TBI participants do not have natural, informal supports, while a proportion of the NHTD participants are expected to have a greater probability of having some type of informal support system.

PBIS will be utilized to a greater extent in the NHTD waiver as the natural supports described above are trained how to more effectively support those NHTD participants with cognitive deficits.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' represents the projected costs of State Plan Medicaid services for individuals in the waiver program. The state must demonstrate that the total Medicaid costs for supporting the waiver participants in the community is less than the Medicaid costs for the nursing home. D' is calculated by using the historical costs for the D' costs reported in the 372 reports, cited above, for the TBI waiver and LTHHCP. It is anticipated that the NHTD waiver will serve individuals who have service needs similar to the individuals served in those existing waiver programs, and that these service needs will be split in a 1:1 relationship, so that half the population's need for state plan services would look like participants of the TBI waiver, and the

other half of the population being similar to participants of the LTHHCP.

The projected impact of Medicare Part D, the percentage of dually eligible participants in the LTHHCP and TBI waiver was found using the eMedNY system. This was 61.4% for the TBI waiver, and 69.6% for the LTHHCP. The reported costs for pharmacy in the TBI waiver and LTHCCP were multiplied by the respective percentages of dually eligible, and the result was subtracted from the historically reported D' amounts. This provided the state with the expected costs for state plan services following the implementation of Medicare Part D. Then the average daily cost for the state plan services by dividing the total cost by the average length of stay for each waiver. These daily post Medicare Part D costs for state plan services associated with the LTHHCP and TBI waiver were added together, and then divided by 2.This figure was then multiplied by the expected average length of stay for each of the three year projections. This calculation is the average state plan costs, minus the impact of Medicare Part D for the expected mix(50/50) of waiver participants in the NHTD waiver.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on historical costs for nursing home care in New York. G is calculated by taking the total cost of nursing home services (not including the ancillary costs), and dividing that amount by the number residents who were in nursing homes, and again by the number of days collectively spent in the nursing home. This gives us the per diem costs for the nursing home. Figures gathered from the MMIS database for the time period April 1, 2003, through March 31, 2004 were used for these calculations.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on historical costs for ancillary services provided in nursing homes in New York. The total costs for G' are divided by the number of residents, and the total number of days. This results in the per diem costs for ancillary services. New York has calculated that the implementation of Medicare Part D will result in an average decrease of $6 per diem. Figures gathered from the MMIS database for the time period April 1, 2003, through March 31, 2004 were used for these calculations.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Initial Service Coordination – Diversion	One Time	500	1	$478	$239,000
Initial Service Coordination – Transition	One Time	500	1	$828	$414,000
Intensive Service Coordination	Per Month	1000	6	$350	$2,100,000
Assistive Technology	1 time/ up to	100	1	$2,500	$250,000
Community Integration Counseling	Per Hour	400	15	$64	$384,000
Community Transition Services	1 time/ up to	500	1	$2,500	$1,250,000
Congregate and Home Delivered Meals	Per Meal	200	200	$10	$400,000
Environmental Modifications	1 time/ up to	40	1	$5,000	$200,000
Home and Community Support Services	Per Hour	700	750	$18	$9,450,000
Independent Living Skills Training	Per Hour	600	104	$32	$1,996,800
Moving Assistance	Per Hour	25	5	$60	$7,500
Wellness Counseling Services	Per Visit	100	3	$30	$9,000
Nutritional Counseling/Educational Services	Per Visit	250	5	$87	$108,750
Positive Behavioral Interventions/Supports	Per Hour	300	100	$48	$1,440,000
Respiratory Therapy	Per Visit	30	15	$51	$22,950
Respite Care Services	Per Day	20	5	$306	$30,600
Structured Day Program	Per Hour	300	300	$16	$1,440,000
Home Visits by Medical Personnel	20 Minutes	50	18	$40	$36,000
Peer Mentoring	Per Hour	100	25	$25	$62,500
GRAND TOTAL:					$19,841,100
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,000
FACTOR D (Divide total by number of participants)					$19,841
AVERAGE LENGTH OF STAY ON THE WAIVER					180 Days

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Initial Service Coordination - Diversion	One Time	750	1	$478	$358,500
Initial Service Coordination - Transition	One Time	750	1	$828	$621,000
Intensive Service Coordination	Per Month	2,500	8	$350	$7,000,000
Assistive Technology	1 time/ up to	150	1	$2,500	$375,000
Community Integration Counseling	Per Hour	1000	21	$64	$1,344,000
Community Transition Services	1 time/ up to	750	1	$2,500	$1,875,000
Congregate and Home Delivered Meals	Per Meal	500	280	$10	$1,400,000
Environmental Modifications	1 time/ up to	60	1	$5,000	$300,000
Home and Community Support Services	Per Hour	1750	1050	$18	$33,075,000
Independent Living Skills Training	Per Hour	1,500	146	$32	$7,008,000
Moving Assistance	Per Hour	63	5	$60	$18,900
Wellness Counseling Services	Per Visit	250	4	$30	$30,000
Nutritional Counseling/Educational Services	Per Visit	625	7	$87	$380,625
Positive Behavioral Interventions/Supports	Per Hour	750	140	$48	$5,040,000
Respiratory Therapy	Per Visit	75	21	$51	$80,325
Respite Care Services	Per Day	50	7	$306	$107,100
Structured Day Program	Per Hour	750	420	$16	$5,040,000
Home Visits by Medical Personnel	20 Minutes	125	25	$40	$125,000
Peer Mentoring	Per Hour	250	35	$25	$218,750
GRAND TOTAL:					$64,397,200
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,500
FACTOR D (Divide total by number of participants)					$25,759
AVERAGE LENGTH OF STAY ON THE WAIVER					254 Days

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Initial Service Coordination - Diversion	One Time	1,250	1	$478	$597,500
Initial Service Coordination - Transition	One Time	1,250	1	$828	$1,035,000
Intensive Service Coordination	Per Month	5,000	9	$350	$15,750,000
Assistive Technology	1 time/ up to	250	1	$2,500	$625,000
Community Integration Counseling	Per Hour	2000	23	$64	$2,944,000
Community Transition Services	1 time/ up to	1,250	1	$2,500	$3,125,000
Congregate and Home Delivered Meals	Per Meal	1,000	300	$10	$3,000,000
Environmental Modifications	1 time/ up to	100	1	$5,000	$500,000
Home and Community Support Services	Per Hour	3500	1125	$18	$70,875,000
Independent Living Skills Training	Per Hour	3,000	156	$32	$14,976,000
Moving Assistance	Per Hour	126	5	$60	$37,800
Wellness Counseling Services	Per Visit	500	5	$30	$75,000
Nutritional Counseling/Educational Services	Per Visit	1,250	8	$87	$870,000
Positive Behavioral Interventions/Supports	Per Hour	1,500	150	$48	$10,800,000
Respiratory Therapy	Per Visit	150	23	$51	$175,950
Respite Care Services	Per Day	100	8	$306	$244,800
Structured Day Program	Per Hour	1,500	450	$16	$10,800,000
Home Visits by Medical Personnel	20 Minutes	250	27	$40	$270,000
Peer Mentoring	Per Hour	500	38	$25	$475,000
GRAND TOTAL:					$137,176,050
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)					5,000
FACTOR D (Divide grand total by number of waiver participants)					$27,435
AVERAGE LENGTH OF STAY ON THE WAIVER					273 Days

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of waiver participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of waiver participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of waiver participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of waiver participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
	☐					

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of waiver participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of waiver participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED WAIVER PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of waiver participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Appendix J - Additional Information

CMS raised questions regarding the State's initial submission of Appendix J, and this re-submission has been crafted to respond to those questions. Some of the questions require this narrative to further answer any remaining questions:

- In the original Appendix J-1, the State had annualized the costs for both sides of the cost neutrality equation. This resulted in a different amount than had been the reported cost for G on the most recent TBI and LTHHCP 372 reports.

- The difference between the costs for G reported in the TBI waiver vs. the LTHHCP is that the TBI waiver reports only those nursing home costs for individuals with a TBI, while the LTHHCP reports for the universe of nursing home residents. For the NHTD waiver, the costs of nursing home residents 18 years of age and older was used to established the G and G' components of the cost neutrality equation. As requested by CMS staff, attached is the transmittal from Department of Health staff which provided this information.

CALCULATIONS FOR D

WAIVER TOTAL PARTICIPANTS	SERVICE	# USERS	% USERS	TOTAL COST	PER UNIT COST	# OF UNITS	# OF UNITS PER DAY /PER PARTICIPANT	180 Days	254 Days	273 Days
TBI										
1,684										
	INITIAL SERVICE COORD.	248	14.73%	$118,544	478	248				
	ONGOING SERVICE COORD.	1,642	97.51%	$5,703,275.00	350	16,295				
	SPECIAL MED EQUIP	209	12.41%	$212,523.00	N/A	209				
	ILS	1,367	81.18%	$10,339,209.00	32	323,100	0.73	131	184	198
	IBP	439	26.07%	$1,584,240.00	48	33,005	0.23	42	59	63
	CIC	1,071	63.60%	$2,762,762.00	64	43,168	0.12	22	31	34
	HCSS	1,227	72.86%	$49,706,991.00	17.7	2,808,305	7.02	1264	1783	1917
	SDP	630	37.41%	$5,494,694.00	15.6	352,224	1.71	309	436	468
	E-MODS	72	4.28%	$540,780.00	N/A	72				
	RESPITE	12	0.71%	$56,610.00	306	185	0.05	9	12	13
LTHHCP										
22,092										
	CONG./HOME DEL. MEALS	3,183	14.41%	4,089,051	5	817810	1.17	211	298	320
	MOVING ASSISTANCE	51	0.23%	21,342	60	356	0.03	6	9	9
	NUTRITIONAL COUNSELING	5,658	25.61%	2,271,681	87	26111	0.02	4	5	6
	RESPIRATORY THERAPY	701	3.17%	598,995	51	11745	0.08	14	19	21